Health Impact Assessment Guidelines Document:

Review and Recommendations

BRITISH COLUMBIA

Ministry of Health and
Ministry Responsible for Seniors

Health Impact Assessment Guidelines Document: Review and Recommendations

For: Policy Development and Project Management
Ministry of Health and Ministry Responsible for Seniors
Victoria, British Columbia, Canada

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The opinions expressed in this report are those of the author and do not necessarily reflect those of the British Columbia Ministry of Health and Ministry Responsible for Seniors.

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EXECUTIVE SUMMARY

Objectives

Policy Development and Project Management Division (PDPM), Ministry of Health and Ministry Responsible for Seniors, has been considering revising its *Health Impact Assessment Guidelines* (1994) document to incorporate the Health Goals for British Columbia, and promoting this document as a policy and program development tool for Health Authorities[1] in British Columbia. However, PDPM felt that the decision on launching such an initiative should be informed by an environmental scan of current Health Impact Assessment (HIA) activity in other jurisdictions, and an analysis of past HIA activity in British Columbia.

The consultant was asked to do the following

- conduct an environmental scan of HIA activity in other jurisdictions;
- analyse any HIA instruments and processes found during this environmental scan in order to determine how the *Health Impact Assessment Guidelines* document might be improved;
- recommend whether or not PDPM should revise and promote the *Health Impact Assessment Guidelines* document as a policy and program development tool for Health Authorities; and,
- recommend what revisions to the *Health Impact Assessment Guidelines* document, beyond the incorporation of the Health Goals, would be desirable should PDPM proceed with revision and promotion of the document either now, or at some point in the future.

[1] The term Health Authorities as used here includes Regional Health Boards (RHBs), Community Health Councils (CHCs), and Community Health Service Societies (CHSSs), though only RHBs and CHCs are mentioned in the *Health Authorities Act*.

The objective of the project then, was to conduct an environmental scan of HIA activity in other jurisdictions, conduct an analysis of past HIA activity in British Columbia, and produce recommendations for PDPM regarding further HIA initiatives.

Summary of Method

The environmental scan involved a literature search on HIA; contact by phone, facsimile and electronic mail with over 70 individuals and organizations; and participation in a number of relevant list servers. Information on HIA instruments and processes was gained largely through individuals directly involved with HIA.

Analysis of past HIA activity in British Columbia was based upon documents contained in PDPM files and interviews with individuals involved in past HIA initiatives.

Results and Recommendations

The environmental scan uncovered a number of HIA instruments and processes, but also found that the practice of conducting HIA of policies and programs is not widespread. Several of the instruments and processes have features which may be worth incorporating into a revised *Health Impact Assessment Guidelines* document should one be produced. These instruments and practices are discussed under "Research Findings." The environmental scan also found that few of the HIA instruments or processes currently in use have been evaluated or are the subject of planned evaluations, and that no evaluation data are yet available on any of the instruments or processes found during the environmental scan.

Analysis of past HIA activity in British Columbia suggests that despite significant inputs of money as well as staff and consultant time, previous efforts to launch HIA as a policy and program development tool in the province have been unsuccessful at all levels, though there is little information available regarding why this has been so.

The report's recommendation therefore, is:

- that PDPM not revise and promote the *Health Impact Assessment Guidelines* document.

However, as PDPM still may decide to revise and promote the *Health Impact Assessment Guidelines* document at some point in the future, and requested that the consultant outline what revisions would be desirable should such a revision and promotion take place, the following recommendations are made:

- that if the revision and promotion of the *Health Impact Assessment Guidelines* document is undertaken, the revised *Health Impact Assessment Guidelines* document should include screening criteria that would help users decide to which policies or progams HIA should be applied. (see Appendix H for a copy of a draft screening tool)
- that a revised *Heath Impact Assessment Guidelines* document should help users consider the effects of the determinants of health on the health concern that a policyor program addresses.
- that a revised *Health Impact Assessment Guidelines* document should contain references to works that explain that organizations such as Health Authorities can partner with other organizations and/or act in an advocacy role in order to improve the determinants of health in their communities.
- that a revised *Health Impact Assessment Guidelines* document should include an example of how a policy or program planner in a Health Authority has applied HIA to a policy or program and made changes based on the assessment.
- that if a revision and promotion of the *Health Impact Assessment Guidelines* document is undertaken, that the revised *Health Impact Assessment Guidelines* document's use be evaluated.

PDPM'S REQUIREMENTS

In 1998, PDPM had responsibility for assisting in the implementation of the Health Goals for British Columbia and the integration of a population health perspective into Health Authority planning and priority setting. With the advent of the Health Goals, PDPM recognized the possibility of using a document previously produced by the Ministry of Health titled *Health Impact Assessment Guidelines* (hereafter referred to as *Guidelines*), to help fulfil these responsibilities. (see Appendix A for a copy of the *Guidelines* document, and Appendix B for a copy of the Health Goals for British Columbia)

The *Guidelines* document was designed to assist policy and program planners to integrate a determinants of health approach into their policies and programs. As the Health Goals for British Columbia are largely based upon a determinants of health conceptual foundation, the similarities between the Health Goals and the *Guidelines* document are readily apparent and PDPM recognized that the *Guidelines* document could be revised to explicitly incorporate the Health Goals. This would provide the Health Authorities with a planning tool that would use the Health Goals to incorporate a determinants of health perspective into Health Authority planning processes.

However, revision and promotion of the *Guidelines* document is only one of many options PDPM could pursue in partial fulfilment of its responsibilities surrounding the Health Goals and population health. PDPM felt that it required more information regarding current HIA practices in other jurisdictions before deciding if it should take this course. At the time of the *Guidelines* document's publication in 1994, British Columbia was the international leader in the HIA of policies and programs, but PDPM felt that British Columbia may no longer enjoy this leadership position. PDPM decided that research should be undertaken to discover what progress other jurisdictions have made in the development and implementation of such HIA instruments before a decision was made regarding further work on HIA by PDPM. PDPM also indicated that a revised *Guidelines* document would be expected not only to incorporate the Health Goals, but to represent an improvement over the original document. It was felt that an environmental scan of HIA activities in other jurisdictions would not only inform the decision whether or not to proceed with the revision and promotion of the *Guidelines* document, but would likely also provide information regarding how the *Guidelines* document could be improved if a revision was undertaken.

The consultant was asked to do the following

- conduct an environmental scan of HIA activity in other jurisdictions;
- analyse any HIA instruments and processes found during this environmental scan in order to determine how the *Guidelines* document might be improved;
- recommend whether or not PDPM should revise and promote the *Guidelines* document as a policy and program development tool for Health Authorities; and,
- recommend what revisions to the *Guidelines* document, beyond the incorporation of the Health Goals, would be desirable should PDPM proceed with revision and promotion of the document.

The remainder of this report is made up of the following sections: *Background, Research Method, Research Findings, Conclusions,* and *Recommendations. Background* deals with HIA generally, the Health Goals for British Columbia, developments in health promotion and population health that have created the theoretical basis for the *Guidelines* document, and the history of the *Guidelines* document. *Research Method* includes information on research methods. *Research Findings* includes analysis of the most relevant HIA instruments and processes that were found during the environmental scan, and discussion of feedback on the draft HIA instrument that was distributed to individuals in the policy community. *Conclusions* contains an overall analysis of current HIA practices in other jurisdictions and past HIA activity in British Columbia. Finally, *Recommendations* outlines recommendations for PDPM regarding future HIA initiatives.

BACKGROUND

Health Impact Assessment

Within PDPM, the term "Health Impact Assessment" (HIA) is used to denote a process of identifying the potential health implications associated with policyor program options (Ministry of Health, 1994b). This type of Health Impact Assessment is "a resource to guide thinking and discussion" rather than a measurement tool (Ministry of Health, 1994a). The Institute of Health Promotion Research at the University of British Columbia defines Health Impact Assessment as "... any combination of procedures or methods by which a proposed policy or program may be judged as to the effect(s) it may have on the health of a population" (Frankish et. al., 1996).

Health Impact Assessment is a process whereby decision-makers consider the broad health implications of a policy or program. It is designed to help decision-makers broaden the range of factors considered when developing policies or programs, modifying existing policies or programs, or making funding decisions. The *Guidelines* document is not intended to outline a process for quantifying and/or measuring the health impact of a policy or program based on indicators, and nor would it be the role of a revised *Guidelines* document to outline such a process.

The *Guidelines* document was designed to be simple enough for decision-makers at the program level in all types of organizations to use without prior impact assessment experience. While a revised *Guidelines* document would be targeted at policy and program planners in the Health Authorities, it would also seek to provide a similarly simple tool.

The other most common use of the term Health Impact Assessment, that involving HIA as part of Environmental Impact Assessment, is discussed under "Other Types of Impact Assessment."

Health Goals for British Columbia

The BC Royal Commission on Health Care and Costs provided much of the impetus behind the creation of the Health Goals for British Columbia when it submitted its report, *Closer to Home*, in 1991. The Commission recommended that provincial health goals be developed to accomplish the following: improve health, reduce inequalities in health, raise awareness of the determinants of health, and link policy decisions and resource allocation to health outcomes (Ministry of Health, 1997).

The Provincial Health Officer was directed by Cabinet in 1994 to begin a consultative process to develop such provincial health goals. Fifty representatives from various sectors began this process and eventually every provincial ministry and almost 100 other organizations participated in consultations. These consultations culminated in the creation of a discussion paper titled *Health Goals for British Columbia: Identifying Priorities for a Healthy Population* which was released in November, 1995. During 1996, the Regional Health Boards organised public consultations in their regions that resulted in a final version of the Health Goals for British Columbia. These Health Goals were approved by Cabinet in 1997, and were published in the document titled, *Health Goals for British Columbia* (Ministry of Health, 1997), and officially released on March 9, 1998.

The six Health Goals are broad statements of aims for the future based upon a determinants of health approach and a World Health Organization definition of health.[2] In keeping with these conceptual foundations, they cover most aspects of life. The six Health Goals are:

1. Positive and supportive living and working conditions in all our communities.
2. Opportunities for all individuals to develop and maintain the capacities and skill needed to thrive and meet life's challenges and to make choices that enhance health.
3. A diverse and sustainable physical environment with clean, healthy, and safe air, water and land.

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[2] The WHO definition used is as follows: "Health is the extent to which an individual or group is able, on the one hand, to develop aspirations and satisfy needs; and on the other hand, to change or cope with the environment. Health is therefore seen as a resource for everyday life, not the objective of living; it is seen as a positive concept emphasizing social and personal resources, as well as physical capacities." (Ministry of Health, 1997).

4. An effective and efficient health service system that provides equitable access to appropriate services.
5. Improved health for Aboriginal peoples.
6. Reduction of preventable illness, injuries, disabilities and premature deaths. (see Appendix B Health Goals for British Columbia for more information on each of the Health Goals)

Documentation on the Health Goals was distributed to a wide variety of government and non-government organizations. However, it is not clear to what extent the Health Goals have been incorporated into the planning processes of these or other organizations as no formal evaluation has been conducted to answer this question. No specific strategies to achieve each goal have been identified and, while possible indicators have been identified by the Provincial Health Officer, and the 1996 Provincial Health Officer's Annual Report did identify some proposed targets for a list of "health challenges" which later became the Health Goals, no provincial targets have been set. The rationale for this was that individual organizations were to set their own goals. Though no evaluation is planned at this time for the newly released Health Goals, anecdotal evidence suggests that the Health Goals are not widely used in planning by government or non-government organizations, though there are some indications that the Health Authorities would be receptive to the concept of using the Health Goals in their planning (Open Learning Agency, 1996, and personal communication, Kim Balfour, June, 1998).

The Theoretical and Historical Context for HIA

The Ministry of Health's direction with population health[3] and HIA have been influenced by broader developments nationally and within British Columbia. Perhaps the most obvious and recent influence has been the release of the Royal Commission on Health Care and Costs' report titled *Closer to Home* (1991) that came out in support for population health activities. The Ministry of Health's response to this report, the policy document titled *New Directions for a Healthy British Columbia*, acknowledged the importance of the determinants of health, called for a regionalized and more participatory health system, and, as one of many specific recommendations, called for the implementation of HIA (British Columbia Ministry of Health, 1993).

While the above are significant recent developments, the population health and determinants of health body of theory behind the *Guidelines* document has been developing for over 20 years. The development of the population health and determinants of health perspective in Canada is discussed below in order to outline the body of theory behind the *Guidelines* document.

Canada became an international leader in health promotion thinking in 1974 when *A New Perspective on the Health of Canadians* (The Lalonde Report) was published. This document, produced under then Minister of Health and Welfare, Marc Lalonde, was the first acknowledgement by a major government that health status is primarily determined by factors other than health care (Health Canada, 1997). The report emphasized the importance of environmental and behavioral threats to health and suggested that the most promising way to improve health was to address these threats rather than pursuing other avenues such as improved health care (Lalonde, 1974).

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[3] The term population health is used within the Ministry of Health, and in this report, to denote a collection of activities including health promotion. While the term population health is often understood now as including health promotion, there traditionally have been distinctions drawn between the two terms. Health promotion has been defined by the WHO and Health Canada as "the process of enabling people to increase control over and improve their health" (WHO, 1986, and Epp, 1986). It emphasizes the importance of socio-economic determinants of health, public participation in the policy-making process, intersectoral action, and health care reform. Population health includes these concepts also, but has tended to emphasize quantitative data and evidence-based decision-making, and has included an inherent acknowledgement of the importance of economic growth (Labonte, 1995). The two were similar enough, however, to be blended under Health Canada's "population health promotion" concept that was widely accepted in the policy community (Health Canada, 1997).

Following the Lalonde Report, changes began to take place within the health policyfield in Canada. A Health Promotion Directorate was formed within Health and Welfare Canada that supported the theory and practice of health promotion here and abroad. Provinces and territories also set up population health units from which to launch their own health promotion efforts, and some municipal health departments began to develop health promotion approaches. In 1984, the preamble of the *Canada Health Act* itself was changed to acknowledge the importance of health promotion (Health Canada, 1997).

The next major milestone in the development of health promotion in Canada and the world was the First International Conference on Health Promotion that took place in Ottawa in 1986. This conference, hosted by Health and Welfare Canada, the Canadian Public Health Association (CPHA), and the World Health Organization (WHO), resulted in the adoption of the *Ottawa Charter for Health Promotion* that has become a document central to health promotion efforts. The *Ottawa Charter* identified the following five strategies that would be needed to pursue health promotion effectively:

1. building healthy public policy[4];
2. creating supportive environments;
3. strengthening community action;
4. developing personal skills; and,
5. reorienting health services (CPHA and Health and Welfare Canada, 1986).

This conference also coincided with the release of a document by Health and Welfare Canada that built upon the Lalonde Report. *Achieving Health for All: A Framework for Health Promotion* (The Epp Report)[5], established the national health challenges of reducing inequalities, increasing illness prevention efforts, and enhancing people's capacity to cope with health problems. The strategy that

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[4] Perhaps the most succinct definition of Healthy Public Policy is the WHO's stating that healthy public policy is, "... characterized by an explicit concern for health and equity in all areas of policy and by an accountability for health impact" (WHO, 1988). This is essentially what is meant by various authors' references to "healthy public policy" though other factors such as public participation may be included in specific definitions. Depending upon its usage, the elements of healthy public policy can be similar to HIA.

[5] *Achieving Health for All: A Framework for Health Promotion* is commonly referred to as the Epp Report as Jake Epp was the Minister of National Health and Welfare at the time of its publication.

the Epp Report proposed in order to meet these challenges was to do the following: widen existing health promotion efforts such as, "education, training, research, legislation, policy coordination, and community development;. . . foster public participation; strengthen community health services; and, promote healthy public policy" (Epp, 1986).

While the *Ottawa Charter* and the Epp Report did not use the phrase "determinants of health" and did not discuss at length the influence on health of such things as income inequalities, employment, and living conditions the way later documents did, these two documents are credited with both increasing the prominence of the health promotion discourse and increasing the emphasis within this discourse on such socio-economic factors as income and employment that would later be termed the "determinants of health" (Health Canada, 1997). (see Appendix C for more details on the determinants of health)

Following the *Ottawa Charter* and the Epp Report, various health promotion initiatives were launched in Canadian jurisdictions. Federal strategies were formed to address specific health issues and groups, universities and colleges implemented courses in health promotion, health promotion research centres were formed, and the volunteer sector became increasingly involved with health promotion. The provincial and territorial governments especially were recognizing that the health care system was too expensive and needed reform. Most provincial and territorial governments were expressing a willingness to focus more on health promotion and community-based care, work on the determinants of health, develop health goals, adopt health promotion principles, and develop structures to promote healthy public policy. In pursuit of health promotion, provincial health promotion programs were strengthened in many provinces, provincial and territorial health councils were formed, and Healthy Community programs were launched (Health Canada, 1997).

In British Columbia, various developments followed from the increasing support for health promotion perspectives. Besides the creation of an Office of Health Promotion within the Ministry of Health in 1989, health promotion activities included: the launch of the HealthyCommunities Network, a healthy schools program, a health-promoting workplaces program, and the hosting of the First National Conference on Health Promotion and Disease Prevention, held in Victoria, BC in 1989 (Altman and Martin, 1994).

Health promotion remained prominent into the 1990's. In 1992, the Canadian Institute for Advanced Research (CIAR) published a working paper titled *Why Are Some People Healthy and Some People Not?*. This working paper discussed and linked together a number of studies showing the influence of socio-economic determinants on health and became one of the most commonly cited works in the field of health promotion (Evans, 1992). The Federal, Provincial and Territorial Committee on Population Health based its earlydiscussions on this CIAR working paper and published *Strategies for Population Health* (1994), and *Report on the Health of Canadians* (1996) that supported the determinants of health perspective and called for further health promotion activities (Federal, Provincial and Territorial Committee on Population Health, 1994 and 1996). Other relevant documents produced in these years included *Towards A Common Understanding* (Health Canada, 1996), and *Health Impacts of Social and Economic Conditions: Implications for Public Policy* (Canadian Public Health Association, 1997). Between 1994 and 1997, initiatives such as the *Perspectives on Health Promotion* project of the Canadian Public Health Association and Health Canada, and the National Forum on Health also provided support for health promotion and the determinants of health perspective (Canadian Public Health Association, 1997, and Health Canada, 1998).

In sum, there is consensus that the factors that have come to be called the determinants of health, such as income and social status, social support networks, education, employment and working conditions, social environments, and physical environments, are important influences on the health of groups and individuals. Since the Lalonde Report, a variety of organizations have called for broad, multi-sectoral action led by government to address these determinants of health. However, while there is consensus that the determinants of health are important, there is less consensus that they should be emphasized at the expense of existing health care services, and health promotion activities do not enjoy the support in all Canadian jurisdictions now that they once did (Health Canada, 1998).

History of HIA in the Ministry of Health

Following the release of *Closer to Home* in 1991, HIA was incorporated as one of 38 priority actions in the policy document *New Directions for a Healthy British Columbia* in 1993. *New Directions* states, "HIA will be part of the approval process for new government policy, programs and

legislation." The Ministry of Health's Office of Health Promotion had already become involved with HIA by the time *New Directions* was published and had developed *Community Health Impact Assessment: For local governments* with the assistance of the British Columbia Healthy Communities initiative in 1993 (Ministry of Health, 1993).

To further support the implementation of HIA as called for by *New Directions*, the Ministry of Health undertook a two-phase initiative to address both the policy and program level of government activity. In phase one, during 1993-94, an interministry working group, led by the Ministry of Health's Population Health Resource Branch, guided the development of the *Health Impact Assessment Toolkit* document (Ministry of Health, 1994b) for use by policy analysts in preparation of the "health implications" section of cabinet submissions.

In 1993, the "Health Implications" section of the document that details the requirements for cabinet submissions, *The Cabinet Document System: Guidelines for Preparing Cabinet Submissions and Documentation*, was revised to reflect a broader understanding of health implications including the determinants of health. It is widely believed, in Canada and abroad, that British Columbia currently requires, at least formally, that all cabinet submissions include a Health Impact Assessment, but *The Cabinet Document System: Guidelines for Preparing Cabinet Submissions and Documentation* does not reflect any requirement for HIA specifically (Scott-Samuel, 1997). No mention is made in the cabinet submission guidelines of HIA or the *Health Impact Assessment Toolkit* document (Deputy Minister's Office, 1993). However, a revision of *The Cabinet Document System: Guidelines for Preparing Cabinet Submissions and Documentation* has been underway for over a year and when the revised document is finalized, it may include more specific mention of HIA (Effie Henry, personal communication, August 5, 1998).

In 1994, the Ministry of Health established another interministry working group that guided the development of the document titled *Health Impact Assessment Guidelines*, which was designed for use in lower level program planning and development as opposed to higher level policy development and cabinet submission formulation. The *Guidelines* document is a shorter and simpler document than the *HIA Toolkit* and was designed to be easy to understand and use (Ministry of Health, 1994a).

Copies of the *Guidelines* document were distributed at the 1994 and 1995 conferences of the Canadian Public Health Association, the 1995 national conference on Community Health Centres, the 1994 international Public Health Association conference, and through British Columbia Healthy Communities (discussed below). The primary distribution of the *Guidelines* document, however, occurred through a series of workshops and presentations delivered throughout BC in 1995. These workshops and presentations are discussed under "HIA Workshops and Presentations."

Use of the *Guidelines* document by British Columbia Healthy Communities

The British Columbia Healthy Communities initiative was launched in 1989 with federal and provincial support. It sought to facilitate the development of intersectoral cooperation at the municipal level in order to promote health. One of the documents used by the communities involved with the initiative was the *Guidelines* document. However, it appears that the document was not used as intended, rather it was used as a post-implementation program evaluation checklist that program participants could use to record what they believed were the effects of a given program (personal communication, John Appleton, August 4, 1998, and Leah Hartley, September 8, 1998). No formal evaluation of British Columbia Healthy Communities' use of the document is available and the initiative has now collapsed due to a withdrawal of funding

HIA Workshops and Presentations

Following the publication of the *Guidelines* document, the Ministry of Health delivered 86 workshops and 26 presentations on HIA in 20 regions across the province. These were delivered between January, 1995, and November, 1995, to approximately 2,000 service providers, educators, managers, and representatives of Regional Health Boards (RHBs), and Community Health Councils (CHCs). The *Guidelines* document was distributed and used as a resource during both the workshops and the presentations (Leski and Pratt, 1995).

The majority of workshop participants were from the health sector, especially public health, mental health, and alcohol and drug services. Participants from other sectors included individuals from the Ministry of Social Services, Ministry of Education, Ministry of Skills, Training and Labour, Ministry of Attorney General, and Ministry of Women's Equality (Miller, March 1998). The objectives of the

workshops were to increase awareness of the determinants of health, familiarize potential users of HIA and the *Guidelines* document with the HIA process the document described, and facilitate the use of this HIA process.

The 26 HIA presentations were delivered to similar audiences. The presentations were shorter than the HIA workshops and had different objectives. Many were delivered in order for groups to assess whether the full workshop would be appropriate for them Others were delivered as short information dissemination sessions for organizations interested in HIA but unable to participate in the workshops. These presentations were not evaluated (Leski and Pratt, 1995).

Evaluation of the HIA Workshops and the *Guidelines* document

The Population Health Resource Branch, now dissolved, wanted an evaluation of the HIA workshops to determine if objectives had been met (i.e., increase awareness of the determinants of health, familiarize prospective users of HIA and the *Guidelines* document with the HIA process the document described, and facilitate the use of the HIA process). It was anticipated that the evaluation report would help inform both future revisions to the *Guidelines* document and decisions regarding future support of HIA initiatives. The evaluation was conducted by two consultants during the period of January, 1995, to November, 1995.

The evaluation's findings were based on three types of data: workshop participants' evaluations, follow-up surveys of workshop participants, and surveys of people who received the *Guidelines* document by mail. The workshop participant evaluation forms were distributed immediately following the HIA workshops and contained primarily qualitative, open-ended questions. The workshop evaluation component of the evaluation report was based upon 578 completed participant evaluation forms.[6] (see Appendix D for copies of the survey instruments used in the evaluation)

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[6] 187 workshop participant evaluation forms were excluded from the analysis. The evaluation report indicates that some of the responses collected by one contractor may have been lost, destroyed or withheld. Due to the risk of bias, the evaluation forms from the 26 workshops delivered by this contractor (Workshop Participant Evaluation Form B) were excluded. The inclusion of this contractor's evaluation forms may have proved problematic in any case as its questions differed from those of the other contractor's evaluation forms (Workshop Participant Evaluation Form A) that were included.

The follow-up survey activities consisted of contact by phone and facsimile with workshop participants between two and three months after the workshop they attended. Individuals who attended only an HIA presentation were not surveyed. One hundred and ten follow-up responses were gathered from workshop participants. Seven of these respondents had attended a slightly altered HIA workshop (the Action Workshops) and were surveyed using a different survey instrument. (see Appendix D for a copy of the Action Workshop survey instrument) These seven responses are reported in amalgamation with the other 103 follow-up responses. Nineteen additional responses were gathered by surveying an unknown number of individuals who requested copies of the *Guidelines* document by mail, but who never attended an HIA workshop. These are discussed separately in the evaluation report.

The evaluation report quantifies the results of the surveys by grouping responses to the open-ended survey questions into response categories created by the evaluators after collection of the response data. The number of responses to a given question placed by the evaluators into each category are reported as a percentage of the total number of responses to that question. (see Appendix E for selected response tables)

The first goal of the workshops was to increase awareness of the determinants of health. The question "How did the workshop affect your understanding of health?" was designed to address this objective. Respondents indicated that the workshops reinforced knowledge of the determinants of health (51%), broadened concepts of health (17%), and provided pointers to specific scientific evidence regarding health determinants (17%). However, when asked "What do you feel was the most important outcome of the workshop?" only 4% of responses fit the "Strengthened and reinforced my understanding of health" category. (see Appendix E for selected response tables)

The second goal of the workshops was to familiarize prospective users of HIA with the *Guidelines* document and the HIA process the document described. When asked "What do you feel was the most important outcome of the workshop?" the largest category of responses was labelled "familiarity with HIA and interest in it" (35%) and the second largest was "using HIA and intention to take action" (27%).[7]

The third goal of the workshops was to facilitate the use of HIA. The Workshop Participant Evaluation Form (A) contained the question "Do you plan to use HIA for program planning, evaluation, resource allocation or anyother purpose?" The results indicate that 58% planned to use it and an additional 13% indicated that theywould try to use it. (see Appendix E for selected response tables)

Although the majority of workshop participants (58%) reported that theyplanned to use HIA, in the follow-up survey only 8% of 110 respondents responded that they had used the *Guidelines* document to do HIA, despite the fact that 73% indicated the workshop had adequatelyprepared them to use the document. The categorization of responses to the two-part question "Have you used the *Health Impact Assessment Guidelines* booklet? If yes, for what purpose?" indicate that 8% had used the document for its intended purpose, 24% had used it for other purposes, and 22% planned or hoped to use it in some way. (see Appendix E for selected response tables) The evaluation report states that 84% of respondents who received the *Guidelines* document by mail found it useful for their purposes but no information is given on what these purposes were.

It appears that the workshops were relatively unsuccessful in getting participants to use the *Guidelines* document for HIA. However, as the follow-up survey instrument made no attempt to determine why the *Guidelines* document was used or why it was not, there is no way to determine what factors account for the great difference between intended use as reported on the workshop participant evaluation forms and the actual usage of the HIA tool. Alternatively, this difference may merely reflect the wording of the workshop participant evaluation and follow-up survey questions. The 58% of respondents who answered "yes" to the question "Do you plan to use HIA for program planning,

[7] Information on other response categories is not provided by the evaluation report.

evaluation, resources allocation or anyother purpose?" may be largely accounted for by the 46% of respondents who reported using or planning to use the *Guidelines* document for purposes other than HIA.

The evaluation report provides no information on what respondents planned to use HIA for when they left the workshops and why most did not conduct HIAs once they returned to their workplaces. The evaluators indicate that lack of support in the workplace is a factor, but no transcribed responses or figures on the number of respondents indicating that this was the case are offered. The evaluation report also includes little feedback regarding the *Health Impact Assessment Guidelines* document itself. While the evaluation was focused on the workshops, more effort to elicit feedback regarding the *Guidelines* document was likely warranted given that the workshops' efforts to facilitate the use of HIA hinged on promoting the use of that document.

There is also no information in the evaluation report regarding whether the *Guidelines* document was useful for assessing policies and programs. Some feedback from participants on the document is quoted in the text of the evaluation report indicating that completing an HIA requires a large amount of time, that clarification of headings is needed, and that there are too many headings. The evaluation however, did not systematically gather feedback on the *Guidelines* document, and the evaluation report subsequently contains little information regarding what users thought of the document and the HIA process.

Overall, then, the evaluation report indicates that few individuals exposed to the *Guidelines* document subsequently conducted HIAs but does not provide any information regarding why this was the case. The report also does not provide any information on how useful the document was to those who did conduct HIAs using the *Guidelines* document, nor much information on how users felt the *Guidelines* document could be revised and improved.

Revisions of the *Guidelines* document (1995-1997)

There have been several attempts to draft a new HIA instrument within the Ministry of Health since the publication of the *Guidelines* document and the *Health Impact Assessment Toolkit* document in 1994. (see Table 1: List of Health Impact Assessment Documents for a list of the documents discussed on the following pages)

Table 1: List of Health Impact Assessments Documents

Health Impact Assessment Guidelines	1994
Health Impact Assessment Handbook: Step by Step Guide (Draft)	1996
Health Impact Assessment Guidelines (Draft)	1996
Health Impact Assessment instrument (Draft) - Modelled after Liverpool Public Health Observatory's instrument	1997

The HIA workshop evaluation report, which was submitted in 1995, included drafts of a revised HIA instrument. These were reproduced in the draft document titled *Health Impact Assessment Handbook: Step by Step Guide* in 1996 (Ministry of Health, 1996). The *Health Impact Assessment Handbook* outlines how to conduct an HIA session and includes revised worksheets recommended by the evaluation report's authors. No information is available regarding the distribution of this draft.

Also in 1996, a draft document that more closely followed the format of the *Guidelines* document (1994) was produced. It discussed what were then the draft provincial Health Goals and included an HIA instrument incorporating the draft goals. For each Health Goal, worksheets in the draft 1996 document asked the user three questions:

1. What is the impact of this policy or program on this factor?
2. What possible actions or changes would enhance this impact?
3. What indicators could be used as evidence of this impact?

This draft document was never finalized or published. (see Appendix F for copies of the *Health Impact Assessment Handbook* and the 1996 draft *Guidelines* document's HIA instrument)

A third draft HIA document was produced in 1997. This draft was a reproduction of an early HIA draft instrument produced by the Liverpool Public Health Observatory. (The instrument published by the Liverpool Public Health Observatory is discussed under "Findings of the Environmental Scan.") The 1997 Ministry of Health draft was never published or distributed.

The *Guidelines* document has not been actively promoted by the Ministry of Health since the completion of the workshop evaluation in 1995 and the document has not been revisited since work was completed on the 1997 draft.

RESEARCH METHOD

The project completed for PDPM involved:

- Research on the background of HIA in British Columbia;
- An environmental scan of impact assessment generally and more specifically other jurisdictions' HIA instruments and processes;
- Development and distribution for comment of a draft HIA instrument; and,
- Development of recommendations regarding future HIA initiatives within PDPM.

The project began with the collection of information about the Ministry of Health's past involvement with HIA, research into the field of impact assessment generally and more specifically HIA, the identification of individuals and organizations involved with HIA, and the collection and review of HIA instruments and processes used in other jurisdictions.

The above involved interviews with Ministry of Health staff and others who have had involvement with Ministry HIA activities. It also involved the review of a variety of documents relevant to HIA published by both the Ministry of Health and other Canadian and foreign organizations. Background research on the concept of HIA was conducted through a literature search, an Internet search, and searches of the following indexes: Medline, FirstSearch, ProceedingsFirst, PapersFirst, Periodical Contents Index, Microlog Index, Humanities and Social Sciences Index, and Canadian Periodical Index.

Over 70 individuals and organizations were contacted by phone, facsimile or electronic mail. The consultant participated in the list servers IAIA_HEALTH, IAIA_STRATEGIC, IAIA_SIA, and HEALTH-PROMOTION. The contacts made became the sources for the HIA instruments that were collected and analyzed.

The HIA instruments and processes used by other jurisdictions were analyzed to determine:

- to what extent they were designed to achieve ends similar to those identified for the revised *Guidelines* document;
- what information existed regarding their effectiveness; and,
- what elements they incorporated that could be included in a revised *Guidelines* document.

Once a number of instruments had been reviewed, a draft HIA instrument was developed and distributed for comment to 23 individuals who have worked with HIA or related projects. Their comments are discussed under "Feedback on the Draft HIA Instrument" and was used to finalize a draft HIA instrument. (see Appendix H for a copy of the finalized draft HIA instrument)

Finally, based on analysis of the Ministry of Health's past HIA activities and the HIA instruments and processes of other jurisdictions, recommendations were developed regarding future HIA initiatives within PDPM. These recommendations cover whether the *Guidelines* document should be revised and if it is revised, what form this revision should take. Evaluation of a revised *Guidelines* document is also recommended and briefly discussed.

One difficulty encountered during the environmental scan was that obstacles prevented broad contact with possible users of the *Guidelines* document. Due to the recent changes associated with policies of regionalization and Better Teamwork Better Care within the British Columbia health care system, a number of guidelines documents have been distributed by the Ministry of Health to the RHBs/CHCs. The Acute and Continuing Care program area requested that PDPM not contact the RHBs/CHCs asking for information regarding the use of the *Guidelines* document or their desire for a revised *Guidelines* document, as it was felt this could lead to confusion and place undue emphasis on one document. Problems were encountered in attempts to contact other possible users of the *Guidelines* document. Due to a variety of factors including the discontinuation of the Population Health Resource Branch and the transfer of responsibility for files among many individuals, contact information on recipients of the *Guidelines* was lost.

RESEARCH FINDINGS

This section is divided into two parts. The first section brieflydescribes several types of impact assessment other than HIA: Environmental Impact Assessment (EIA), Social Impact Assessment (SIA), Strategic Environmental Assessment (SEA), and Health Risk Assessment. Because the terms used to describe various assessment activities overlap, as do the activities conducted under procedures with different names, it is worthwhile to discuss these other types of impact assessment and their relationships to HIA. Although each type of assessment discussed has elements that are relevant to the *Guidelines*, there are also significant differences that make them less applicable. For this reason, and because of time constraints, they are reviewed briefly, but examples of impact assessment instruments and processes to inform this report's recommendations were not gathered from these fields. The second part of this section describes the HIA instruments and processes that were gathered during the environmental scan.

Types of Impact Assessment Other Than HIA

Environmental Impact Assessment

The first method of environmental impact assessment was established when the United States Congress passed the *National Environmental Protection Act*(NEPA) in 1970 (Morris and Therivel, 1995). The NEPA required that proponents of development projects and policies that involved federal land, funding, or jurisdiction submit an environmental impact statement (Burge, 1995). Since then, Environmental Impact Statements, or Environmental Impact Assessments (EIAs), have become requirements for many development projects in jurisdictions around the world. Not only do many countries and provinces or states have statutes that require EIAs, but international institutions such as the United Nations, World Bank, World Health Organization, and European Union have also recognized the need for EIAs of development projects (Birley, 1995; Craig et. al., 1994; Environment Australia, November 1997; Health Canada, 1997; World Bank, no date).

Environmental Impact Assessments, wherever they are carried out, normally involve a similar set of steps, though the details of how these steps are carried out will, of course, depend upon the nature of the project and the relevant EIA requirements. Essentially, an EIA involves the following:

1. Analysis of whether an EIA is required, what the key impacts to be considered are, what area will be impacted, and what mitigation measures might be considered;
2. Collection of information about the area likely to be impacted and the development of impact predictions by the project proponent;
3. Development of proposals for how anticipated undesirable impacts can be mitigated; and,
4. Monitoring of actual impacts when the project is implemented.

Environmental Impact Assessment is relevant to the HIA pursued by PDPM in two ways. First, it has influenced how HIA is conducted. For example, the use of a screening tool is an innovation borrowed from the field of EIA. Second, HIA, though of a different type than outlined in the *Health Impact Assessment Guidelines* document, is incorporated into some Environmental Impact Assessment processes.

Though there are certainly similarities between the practice of HIA outlined in the *Guidelines* document and both EIA generally and the HIA that is sometimes conducted as part of EIA (Environmental Health Impact Assessment or EHIA), this environmental scan has focussed on non-EIA activities due to several key differences[8]. First, EIA is generally development project focussed (Sadar, 1996). This project focus leads EIA to focus on those considerations that are relevant to the construction and operation of a development project or similar undertaking. Such considerations are less relevant to the policies and programs of a health authority that a revised *Guidelines* document would be used to assess. Secondly, EIA processes, including EHIA, are designed to be implemented by experts. Such processes would not be appropriate for a revised *Guidelines* document that would have to be used by a wide variety of individuals, including those with no scientific or assessment experience. Thirdly, EHIA is overwhelmingly concerned with only the negative health consequences of projects. The HIA process outlined by the *Guidelines* also attempts to identify the broad health benefits of an undertaking so that they can be increased. Each of these differences makes EIA and EHIA processes less relevant to an environmental scan seeking information that could inform a revision of the *Guidelines* document.

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[8] Most EIA studies have not involved little or no health data. It has been estimated that 90-95% of EIAs lack the inclusion of any health expertise (Sloof's study cited in Davies and Sadler, 1997).

With reference to EHIA specifically, most EHIAs give little consideration to socio-economic determinants of health, unlike the *Guidelines* document. Most EHIAs have largely been concerned with the effects of projects on physical health such as the increased risks of mortality, morbidity and injury (Davies and Sadler, 1997). Assessments conducted under the *Canadian Environmental Assessment Act* (1992) exemplify this pattern. The *Act* allows the consideration of health impacts, but assessments conducted under the *Act* normally use a narrow definition of health impacts that does not include such broad considerations as the determinants of health (John Mathers, personal communication, May, 1998, and Canadian Environmental Assessment Office (CEAO), 1998 and CEAO, no date).

However, despite the infrequence of EHIA, some jurisdictions are moving towards increased use of EHIA and some are also moving towards increased consideration of the determinants of health in their EHIA processes. The Environmental Assessment Office in British Columbia routinely considers the relevance of the determinants of health when assessing project proposals (Terry Peace, personal communication, August 17, 1998 and EAO, May, 1997). Other jurisdictions such as New Zealand and Australia have also recognized the importance of considering the determinants of health when assessing proposals (National Health and Medical Research Council, 1993, and Public Health Commission, 1995). However, the methods for inclusion of these determinants of health considerations as part of EHIA are still largely under development.

So, while EIA is not irrelevant to a revision of the *Guidelines* document, with consideration of PDPM's intended use of HIA and the limited time available for an environmental scan, the scan has excluded EHIA activities.

Social Impact Assessment

Social Impact Assessment (SIA) is a branch of EIA. It emerged in the 1970's following the *National Environmental Policy Act* (NEPA) in the United States. SIA became an integral part of EIA, providing analysis of the impacts that environmental policy alternatives and development projects would have upon human populations, and is now a part of EIA processes in many jurisdictions (Burge, 1995).

SIA is defined by Roy Bowles as, "the systematic ... appraisal of the impacts on the day-to-day quality of life of persons and communities when the environment is affected by a development or a policy change" (cited in Burge, 1995). SIA seeks to recognize and quantify the impacts on human populations affected by environmental alteration in an anticipatoryfashion (Burge, 1995). It concerns itself with factors such as social interaction patterns, psychological well-being, quality of life, participation in public decision-making, institutional variables, as well as changes in socio-economic status, all in relation to potential migrants and community residents who will be affected by a development project or policy. Such an assessment seeks to identify what undesirable social effects can be expected from a project or development policy and make recommendation on how changes in implementation can mitigate these undesirable effects (Burge, 1995).

The basic steps of SIA have much in common with the type of HIA that PDPM is pursuing, typically including identification of the project, determining the need for an SIA, predicting project effects, and attempting to mitigate undesirable impacts. Also many of the variables used in SIA are relevant to the determinants of health. However, SIA and the HIA pursued by PDPM are also quite different. While SIA can be used to assess the impact of a policy or program, the field of SIA, like the broader field of EIA, has been very project-focused. The field is primarily concerned with the impacts upon a community of a specific development project and the distribution of benefits and burdens that the project will bring to the surrounding community (Krawetz, 1991). Also, SIA procedures, like other procedures carried out as part of EIA, have been developed for implementation by experts. As with EIA, SIA's project focus and assumption of expert implementation makes it less relevant to this environmental scan. With consideration of PDPM's needs, and due to time limitations, the environmental scan has excluded SIA activities from the environmental scan.

Strategic Environmental Assessment

Strategic Environmental Assessment (SEA), a sub-field of EIA, seeks to systematically address the environmental impact of policies, programs, and plans, rather than specific projects. However, the still-emerging procedures for SEA, like those for EIA in general, are designed to be implemented by experts (Therivel et. al., 1992). As with EIA, there may be lessons to be learned from SEA models but due to time constraints, SEA has been excluded from the environmental scan.

Health Risk Assessment

While bearing similarities to the type of HIA outlined in the *Health Impact Assessment Guidelines* document, Health Risk Assessment is substantially different and it has been excluded from the environmental scan. Health Risk Assessment, the "estimation of the likelihood of adverse effects from exposure to specified health hazards or from the absence of beneficial influences," differs from HIA in many ways (US Department of Health and Human Services, Task Force on Health Risk Assessment, 1986, cited in Frankish et. al., 1996). It is generally focused on disease prevention and specific exposure risks, is concerned with minimizing harm rather than both minimizing harm and increasing benefits, and is typically tied to a given project or development plan, rather than the wider impacts of policies and programs (Frankish et. al. 1996). For these reasons, Health Risk Assessment has been excluded from the environmental scan.

HIA Instruments and Processes

When the *Guidelines* document was published in 1994, British Columbia was considered an international leader in HIA applied to policies and programs. At that time, the *Guidelines* document was perhaps the most advanced and practical HIA instrument available. While the Ministry of Health has not been active in this type of HIA for approximately three years now, few other jurisdictions have been active in developing this type of HIA either.

The literature search uncovered little secondary material regarding HIA of policies and programs. Most literature on HIA involves HIA as part of EIA and is of limited relevance to a revision of the *Guidelines* document. However, relevant primary materials were found. The most relevant HIA practices reviewed, those of the Nova Scotia Department of Health, the Liverpool Public Health Observatory, the Federation of Swedish County Councils, and the Netherlands, are discussed below.

In addition, the environmental scan found a number of documents that outline HIA or HIA-like procedures but that ultimately offer limited insight into whether the *Guidelines* document should be revised and promoted and what form such a revision would take. While the documents' characteristics vary, problems include being too complex for local Health Authorities to implement, offering no new HIA techniques, and/or inherent flaws. (see Appendix G for an analysis)

Liverpool Public Health Observatory Instrument

One of the organizations most active in the field of HIA currently is the Liverpool Public Health Observatory. The Observatory has recently developed and begun to implement an HIA instrument. It has been piloted in an assessment of the Single Regeneration Budget (SRB) crime and juvenile disturbance reduction projects in Knowsley, England.

The Liverpool model builds on the HIA approaches that have been used in BC, in the field of EIA, and that are outlined in *Policy Appraisal and Health.* (see Appendix G for a discussion of *Policy Appraisal and Health*) The application of the model, which is still being further developed and revised, includes:

- using screening criteria to determine if an HIA is warranted;
- profiling affected communities, including the gathering of socio-demographic data and information on disadvantaged groups who are likely to be at risk;
- identifying key informants in the community who can provide information throughout the HIA process;
- identifying potential health impacts by project stage and category of health determinant;
- prioritizing impacts identified;
- identifying further research and information needs; and,
- recommending a course of action based on consideration of alternative options (Liverpool Public Health Observatory, 1997).

Anticipated impacts noted in the impact identification stage are categorized according to the following influences on health: biological factors, personal/family circumstances and lifestyle, social environment, physical environment, public services, and public policy. Assessors are asked to note if each impact is expected in the project development stage and/or the project operation stage. For each project development or operational activity, the category of health influence that the activity impacts is identified, potential positive and negative impacts are identified, and the certainty of the potential impacts is estimated (definite, probable or speculative). The instrument is flexible enough to be applied by experts or laymen, though the depth of analysis the instrument provides would vary depending upon the skills of the assessor.

The Liverpool instrument has a number of characteristics that could be incorporated into a revised *Guidelines* document. The use of a screening tool is one.[9] In addition, the matching of specific elements of an initiative to specific potential health impacts may be worth considering. Lastly, assessment of a potential impact's probability of occurring may also be useful.

Overall, while the Liverpool instrument has been heavily influenced by EIA and includes some elements that appear to be inappropriate for a revised *Guidelines* document, such as the emphasis on separating assessment of the development and operation phases of initiatives,[10] the Liverpool instrument does incorporate a number of characteristics that are instructive.

Quality of Life Impact Assessment Tool

In January, 1998, the Nova Scotia Department of Health produced a draft Quality of Life Impact Assessment Tool (Nova Scotia Department of Health, 1998a). The tool is designed to help decision-makers incorporate consideration of the determinants of health into, and identify potential stakeholders/partners during, the policy and program development process (Nova Scotia Department of Health, 1998a). It uses the common term "quality of life" to communicate the intersectoral nature of the determinants of health and the type of analysis that is needed to address population health effectively (Nova Scotia Department of Health, 1998b).

The Quality of Life Impact Assessment Tool consists of a list of nine statements regarding what is known about the impacts of the determinants of health. With each statement is a question that asks how the initiative being assessed would impact on a determinant of health. In the margin beside each statement and corresponding question is a list of specific factors to consider when answering the question. This simple design may make application of the Tool convenient for non-experts. While the Quality of Life Impact Assessment Tool is very similar to the *Guidelines* document, it includes two features that could be incorporated into a revision of the document:

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[9] The screening tool within the Liverpool HIA instrument influenced the development of the Ministry of Health's 1997 draft HIA screening tool included in Appendix H.

[10] Such considerations are very relevant for development projects since the health impacts during construction of a dam, for example, may be much different than during its operation. This consideration is less important for assessing the policies or programs of a local health authority.

- The use of simple statements that reminds the user of the relevance and importance of each determinant of health; and,
- The use of "Factors to Consider" on the same page as the assessment questions that can act as convenient prompts for the user.

The Quality of Life Impact Assessment Tool was pilot tested in two Nova Scotia Ministries during the spring and summer of 1998. Evaluation results are not yet available.

Federation of Swedish County Councils' HIA Instrument

The HIA instrument promoted by the Federation of Swedish County Councils (FSCC) was developed as part of the Public Health Program, a program involving county councils and municipalities in Sweden. The FSCC instrument is designed to be used in conjunction with national public health targets, which were developed by a Government Commission of Inquiry, or with the targets that have been developed individually by many councils and municipalities. However, it does not incorporate any targets into the instrument itself (Federation of Swedish County Councils, 1998).

Developed with input from community residents, elected representatives, as well as public health practitioners and public health scientists, the FSCC instrument is designed to be simple enough for administrators and those directly involved in policy decisions to use, but also adequate to form the basis of more thorough analyses involving expert input. There is a recognition that exact answers may not be available to all the questions the instrument raises, but the Federation's goal in instituting HIA is merely "to initiate a process leading to greater attention being paid to health impacts in decision-making" (Federation of Swedish County Councils, 1998).

The FSCC instrument is actually a collection of three instruments of varying complexity: the Health Question, the Health Matrix, and the Health Impact Analysis. The expectation is that users such as administrators will seek more expert input if the Health Matrix is used than if the Health Question is used, and still more if the Health Impact Analysis is used. The Health Question version, the most simple of the three, is made up of three questions regarding a given proposal's predicted effects on the social environment, risk factors, and the relevant health targets and objectives.

The Health Matrix is more complex. It asks the user to rate a proposal's impact as positive or negative, in both the short term and the long term, on both prioritized (disadvantaged) groups and the entire population on a number of variables. The variables chosen are based on a determinants of health concept and also bear some resemblance to the Health Goals for British Columbia. They are as follows: Democracy/opportunity to exert influence/equality, financial security; employment/meaningful pursuits/education; social network; access to health care and welfare services; belief in the future/life goals and meaning; physical environment; and living habits. Users are encouraged to add their own variables to suit the proposal being assessed. If, after completion of the matrix, a proposal is associated with many negative effects, the FSCC instrument suggests that further investigation of the proposal's impacts take place.

The third version, the Health Impact Analysis, consists of a series of questions that ask the user to identify what disadvantaged groups may be affected by the proposal being assessed, what health targets are applicable, what short and long term health risks will be affected, how the social environment will be affected, and what alternative policies are available.

The FSCC instrument bears many similarities to the *Guidelines* document. It is based upon the determinants of health, shows a specific concern for disadvantaged groups, and is simple enough to be readily accessible by those involved in local health decisions. Features of the HIA instrument that may be worth consideration include the use of more than one version. This may allow users to become comfortable with a very simple tool before using a more complex one. Also, the emphasis on both short term and long term effects may be valuable. Lastly, the Federation HIA Instrument explicitly asks users to add their own variables to the assessment where they feel this is appropriate. As every policy or program decision will have its own context and characteristics, an HIA instrument would be self-defeating if it acted to constrain rather than broaden thinking on a proposal's impacts. Making it explicit that users can adapt the tool to their own situations is likely worthwhile. However, while the Federation HIA has several features that may be worth incorporating into a revised Guidelines document, it should be noted that no evaluation of the instrument has taken place yet.

Health Impact Screening in The Netherlands

The Netherlands Ministry of Health has begun to use an HIA process called HIS (Health Impact Screening) to assess the health impacts of various policies within the ministry and without to ensure that health considerations are taken into account in as many public policies as possible. HIS is based upon the idea that the usefulness of Health Impact Assessment (i.e. its ability to effect changes that improve health), is dependant upon two things: its ability to identify the cause and effect relationships associated with a policy, and the extent to which policy formulation can be changed after the completion of the HIA (Putters and Van der Grinten, 1998). HIS includes the collection of information to address both of these factors.

Before a full HIS analysis is completed, a Basic HIS is conducted that assesses the impacts of a policy in a preliminary fashion to determine if it is significantly health impacting. If it is, then a HIS Follow-up begins and proceeds on two fronts. The first involves the collection of basic HIA information including the goals of the policy in question, its target groups, possible causal links, and the seriousness, irreversibility, and duration of its effects. The second involves an analysis of the administrative context that the policy is being formulated in and the possibility of the HIS effecting change (Putters, 1997).

It is HIS's innovative attempts to "clarify the administrative possibilities and opportunities for influencing policy making in practice" that sets it apart from most HIA efforts. This part of the analysis provides information on a variety of matters including the following: the positioning of health interests among the other interests, when the information produced by the HIS can be best used, how receptive other actors will be to health interests, and whatchanges could benefit health and other interests (Putters and Van der Grinten, 1998).

The administrative possibilities component appears to be a useful innovation. The revised *Guidelines* document could perhaps encourage users to consider the other actors involved and affected by a decision, what their interests are, what possibilities to effect chang exist, and how the information produced by the HIA can best be used.

Feedback on the Draft HIA Instrument

Based in part on review of HIA instruments and processes in other jurisdictions, a draft of a revised HIA instrument was created by the consultant in July, 1998. While most HIA instruments are accompanied by additional information such as explanations of the determinants of health and HIA, the core of any HIA document is the HIA instrument itself. It is the HIA instrument, or worksheet in many cases, that actually sets out what questions the user should answer and what factors theyshould consider in their assessment of a given proposal. The core, therefore, of the *Guidelines* document is the worksheets on pages 8 and 9. (see Appendix A)

The draft instrument created in July, 1998, incorporated the Health Goals for British Columbia, as well as some of the characteristics of other HIA instruments that had been reviewed by this date. It consisted of a screening tool designed to help users determine if an HIA should be conducted for a given proposal, and a worksheet to be used for those proposals where an HIA is deemed appropriate.

The worksheet was divided into two parts. Part One asked users to consider the determinants of health contributing to the health concern the proposal seeks to improve. Part Two asked users to consider what potential impacts the proposal itself might have. The draft instrument was distributed to 23 individuals currently or previously involved with HIA or related projects. Eleven recipients responded. While recipients were asked to comment broadly, the following four questions were provided to guide their responses:

1. Are the screening tool and worksheet easy to understand?
2. Do you think the screening tool is useful?
3. Do you think the worksheet would be useful to decision-makers such as those in a Health Authority?
4. Are there any changes you could recommend?

Feedback on the draft HIA instrument was varied and some individuals' responses were diametrically opposed. For example, some respondents felt that the use of a screeningtool was a useful innovation, while others felt that all policies should have HIA applied to them. Disagreement also surrounded the

use of the Health Goals. Some felt that the Health Goals for British Columbia provided a useful framework for HIA, while one respondent indicated that their use might weaken the HIA process by subordinating it to the Health Goals.

One common theme in several responses was that the wording of the draft was confusing and that the division of the worksheet into its two parts was unnecessary. Some respondents felt that the repetition of the Health Goals in Part One and Part Two was repetitive. Some negative feedback was also received regarding the worksheet's attempt to prompt users to consider what factors contribute to the health problem the policy or program addresses as opposed to merely the effects of a given proposal on health. This negative feedback was not unexpected however, since HIA has generally not included such considerations in the past.

Based on the feedback from the respondents, the revised draft includes an HIA worksheet with only one part and includes more extensive explanation of how the worksheet should be used. (see Appendix H for a copy of the revised HIA screening tool and worksheet draft)

CONCLUSIONS

As indicated under "PDPM's Requirements," the consultant was asked to do the following

- conduct an environmental scan of HIA activity in other jurisdictions;
- analyze any HIA instruments and processes found during the environmental scan to determine how the *Health Impact Assessment Guidelines* document might be improved;
- recommend whether or not PDPM should revise and promote the *Guidelines* document as a policy and program development tool for Health Authorities; and
- recommend what revisions to the *Guidelines* document, beyond the incorporation of the Health Goals, would be desirable should PDPM proceed with revision and promotion of the document.

The environmental scan revealed that most HIA being conducted currently could more accurately be classified as EHIA, since it is being conducted as part of EIA activity. EIA and EHIA activities were acknowledged as relevant to the type of HIA outlined by the *Guidelines* document, but due to key differences between EIA and the type of HIA outlined by the *Guidelines*, as well as time constraints, EIA activities were not studied in depth and Impact Assessment instruments and processes were not drawn from this field to inform the conclusions and recommendations of this report. The same holds true for the other non-HIA types of Impact Assessment discussed.

The environmental scan did reveal that a number of jurisdictions and organizations are pursuing the type of HIA outlined in the *Guidelines* document, and a variety of HIA instruments from other jurisdictions were gathered and analyzed. Some of these were more instructive than others. Those dealt with in the body of the report under "Research Findings" included features worth considering for inclusion in a revised *Guidelines* document. Those instruments and processes dealt with in Appendix G were interesting and relevant to PDPM's HIA activities, but not particularly useful for informing a revision of the *Guidelines* document.

Overall, while there are a number of HIA practices and instruments upon which PDPM could model a revised *Guidelines* document, none appear to offer characteristics that could be expected to

substantially improve the *Guidelines* document. Also, no evaluation data is available for any of the practices or instruments uncovered by the environmental scan. While individuals involved with HIA in every jurisdiction believe it is valuable, and are positive about the tool they are using, only the Quality of Life Impact Assessment Tool has been formally evaluated, and no information is yet available on the results of this evaluation. In short, there is no reliable evidence to date that the HIA processes in place in other jurisdictions are creating policy or program changes consistent with the determinants of health perspective, and no evidence to date that HIA processes actually improve health status, though it should be recognized that the latter would be extremely difficult to gather due to the long timelines involved and difficulties in establishing causal connections between population health initiatives and improvements in population health. An initiative to revise and promote the *Guidelines* document would have to proceed without evidence that HIA has been successful elsewhere.

With regards to the success of HIA in British Columbia, limited information is available on the use of the *Guidelines* document, and no information is available regarding the document's effectiveness in actually prompting changes during policy or program development. Therefore, no information is available regarding the utility of changes it may have prompted. Evidence provided by the 1995 evaluation of the HIA Workshops suggests that it is difficult to get people to use the *Guidelines* document for any purpose and extremely difficult to get them to use it for conducting HIA. No information is available on the current usage of the *Guidelines* document but anecdotal evidence suggests that it is seldom used in any organization, including the Health Authorities. Large scale efforts in the past, including interministerial committees and the HIA Workshops, have failed to launch HIA in British Columbia at the cabinet submission or Health Authority program level in the past, though anecdotes attributing success to the *Guidelines* document in small local projects do exist (Gordon Miller, March, 1998). Though the *Guidelines* document could be improved, in part by incorporating some features of HIA instruments analyzed during the environmental scan, there is no evidence that such improvements would contribute significantly to greater success with a revised *Guidelines* document in the current environment than was experienced with the original document.

One reason that the Guidelines document may have been little used is that it invites users to systematically consider the determinants of health and the impact that their organization has

on them, but does little to inform users how their organizations can work to improve these determinants. The *Guidelines* document instructs the user to assess a policy or program using the *Guidelines* document, recognize potential impacts on the determinants of health, and adjust the policy or program accordingly. However, a decision-maker in a Health Authority may realize that most of the determinants of health are largely beyond his/her control, and that those partially within the organization's control can be affected only marginally if the organization acts alone. Partnerships with other sectors and advocacy action are often necessary if the determinants of health are to be significantly affected and such intersectoral action can be difficult to arrange and maintain.

Another reason that the *Guidelines* document may have been little used is that it is focused on how policy and program planners can mitigate the ill effects and improve the positive effects of their programs on the determinants of health, but does not assist in consideration of how the determinants of health affect the health concerns the health authority faces. At the local level, altering policies and programs in response to the effects of the determinants of health may be more realistic than altering them in an attempt to create or mitigate effects on the determinants of health (personal communication, Thea Vakil, June, 1998). (see Appendix H for a draft HIA worksheet)

An additional weakness of the *Guidelines* document may be that users are not provided with a detailed example of how HIA can be applied to a policy or program. Such an example would likely be helpful to users. Both the evaluation of the HIA Workshops and the feedback received on the draft HIA Instrument distributed in 1998 indicated that users of HIA like to have an example of the HIA's application that they can refer to as they learn about and apply HIA (Leski and Pratt, 1995). Such an example should clearly outline the step by step application of HIA, and illustrate how common difficulties can be overcome. A real example would be preferable as it offers legitimacy to the process and encouragement to potential users. Such an example could possibly be drawn from the files of the Determinants of Health Project.[11] (see "Recommendations" for recommendations on the revision of the *Guidelines* document)

[11] The Determinants of Health Project collected information on Health Authority activities that sought to improve the determinants of health.

Acknowledging that the *Guidelines* document may be revised and promoted at some future date, PDPM requested that the consultant outline what a revision of the *Guidelines* document should entail. There are several reasons PDPM may decide to revise and promote the *Guidelines* document at some point in the future. PDPM is assisting in the implementation of the Health Goals and the provision of an HIA tool incorporating the Health Goals is one available implementation strategy. Also, there are indications that the Health Authorities would welcome Ministry assistance in the implementation of the Health Goals.

A 1996 Open Learning Agency needs assessment study investigated the perceived need for a determinants of health approach in the RHBs and CHCs, and the opinions of board members and staff regarding what was needed to further incorporate this perspective into planning, policy-making and decision-making. The majority (86%) of RHB/CHC board members and staff surveyed felt that the determinants of health would be important or very important in the future planning, policy development and decision-making in their RHB/CHC. Respondents also indicated that the most important support that was required to implement a determinants of health approach was help in applying the determinants of health framework and training in specific methods and tools. Overall, the recommendations included in the needs assessment report call for increased support of RHBs and CHCs in their attempts to incorporate a determinants of health perspective into their planning (Open Learning Agency, 1996). This fits well with PDPM's responsibility to assist with the integration of a population health perspective into health authority planning and priority setting, and to assist with the implementation of the Health Goals. A revised *Guidelines* document could help fulfil these responsibilities and a revised *Guidelines* document incorporating the Health Goals could act as an awareness building reference document on the Health Goals and the determinants of health. (see "Recommendations" for recommendations on the revision of the *Guidelines* document, and Appendix H for a copy of the Draft Health Impact Assessment Instrument)

Should the *Guidelines* document be revised and promoted at a future date, the opportunity would arise to evaluate the document and its use. The lack of information regarding the usage and utility of the current *Guidelines* document is regrettable. As discussed under "Evaluation of the HIA Workshops and *Guidelines* document," the only evaluation of the *Guidelines* document's use conducted to date provided little or no information on why the document was rarely used for HIA and whether it led to

program or policy changes in cases where it was used. Evaluative data is similarly lacking for the use of the *HIA Toolkit*, and the use of the *Guidelines* document in other organizations such as Healthy Communities.

Evaluative data on a revised *Guidelines* document would be valuable. However, any evaluation of a revised *Guidelines* document supported by PDPM will be limited by resource constraints. While it may be ideal to develop an evaluation that attempts to determine the outcomes of a revised *Guidelines* document's use (i.e. Do programs developed using the *Guidelines* document improve health more than others?), it is more realistic to anticipate that an evaluation would gather information on how widely the document is used, how it was received, and if its use leads to policy or program changes that are consistent with a determinants of health approach.

Since strategies for the incorporation of a population health perspective into Health Authority planning are currently under development and it is not yet known how a revised *Guidelines* document would be included within this strategy in the future, detailed discussion of how a revised *Guidelines* document would be evaluated is not appropriate at this time. Preliminary discussion of what such an evaluation might entail is included under "recommendations."

RECOMMENDATIONS

Recommendation: **It is the recommendation of this report that PDPM not revise and promote the *Guidelines* document.**

Rationale: This recommendation is based upon the available information regarding the characteristics and successes of HIA practices elsewhere, and the available information regarding the past success of HIA in British Columbia. In short, there is no reliable evidence to date that the HIA processes in place in other jurisdictions are creating policy or program changes consistent with the determinants of health perspective. An initiative to revise and promote the *Guidelines* document would have to proceed without evidence that HIA has been successful elsewhere.

Recommendation: **A revised *Guidelines* document should include screening criteria that would help users decide to which policies or programs HIA should be applied.**

Rationale: Inclusion of HIA screening criteria is an innovation borrowed from the Liverpool Public Health Observatory HIA Instrument (Liverpool Public Health Observatory, 1997). The use of such screening criteria allows policy and program planners to quickly assess whether a given policy or program should be thoroughly assessed using HIA, and should ensure that resources devoted to HIA are allocated as appropriately as possible. (see Appendix H for a copy of the Draft Health Impact Assessment Screening Tool)

Recommendation: **A revised *Guidelines* document should help users consider the effects of the determinants of health on the health concern that a policy or program addresses.**

Rationale: A revised *Guidelines* document should assist decision makers in systematically considering what determinants of health contribute to a given health concern that a policyor program addresses. (see the Health Impact Assessment Worksheet [Draft] in Appendix H)

Recommendation: **A revised *Guidelines* document should contain references to books and other documents that explain how organizations such as Health Authorities can partner with other organizations and/or act in an advocacy role in order to improve the determinants of health in their communities.**

Rationale: References to such information sources would be very helpful for those who have realized that their organizations can have only marginal impact on the determinants of health if acting alone, but who do not know how to partner with other organizations or act in an advocacy role to achieve significant impacts on these determinants.

Recommendation: **A revised *Guidelines* document should include an example of how a decision-maker in a Health Authority has applied HIA to a policy or program and made changes based on the assessment**

Rationale: Users of the Guidelines document who are unfamiliar with such instruments would likely find a template or example to work from helpful. Such an example should clearly outline the step by step application of HIA and illustrate how common difficulties can be overcome.

Recommendation: A revised *Guidelines* document should be evaluated.

Rationale: An evaluation could consist of a short survey of Health Authority Chief Executive Officers designed to gather general information on how widely the revised document is used, and perhaps three case studies of Health Authorityorganizations using the document that would answer more detailed questions. Such case studies should address the followingquestions:

- How was the document used?
- What factors appear to account for the document being used as intended or being co-opted for other uses (e.g. as a determinants of health reference document)?
- What policy and program development changes can be attributed to the use of the *Guidelines* document?
- Do these changes appear to be consistent with a determinants of health perspective?
- Are users satisfied with the document and what changes to the document would they recommend?

APPENDICES

APPENDIX A

Health Impact Assessment Guidelines (1994)

HEALTH IMPACT ASSESSMENT

Guidelines

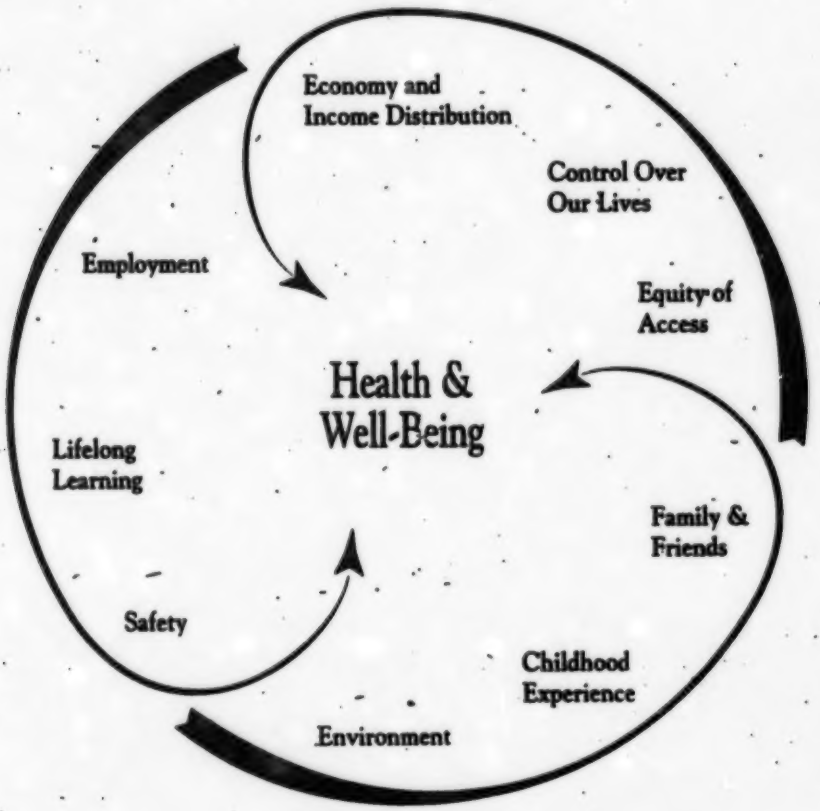
A resource for program planning and development

BC Ministry of Health and
Ministry Responsible for Seniors

WHAT MAKES US HEALTHY?

Many aspects of our lives influence our health. These factors include the social, economic, and physical environment, lifestyle, human biology, and health services. Health Impact Assessment focuses on social, economic, and environmental factors such as strength of the economy, distribution of income, control over decisions that affect our lives, support of family and friends, childhood experiences, and quality of the physical environment.

Social, economic and environmental factors that effect the health of individuals and communities:



SOME KEY SOCIAL AND ECONOMIC FACTORS THAT MAKE US HEALTHY

Economy and Income Distribution

The poorer people are, the less healthy they are likely to be. B.C. babies born in low income neighbourhoods are twice as likely to die before their first birthday than are babies in wealthy neighbourhoods. The link between income and health continues throughout our lives. Studies in provinces and cities in all parts of Canada consistently show that people at each step of the income scale are healthier than those on the step below.

Employment and Working Conditions

People are less likely to become sick and more likely to excel in their jobs when they feel appreciated at work. A Canadian study found that people who are unemployed have significantly more anxiety, activity limitation, health problems, and physician visits than the employed. Also, people with high-stress jobs and little decision making authority are more likely to develop high blood pressure and to die from heart attacks.

Childhood Experiences

Early childhood experiences have a lasting effect on a person's life. Studies have shown, for example, that high-risk children involved in preschool enrichment programs experience much lower rates of teen pregnancy, delinquency, and drug use. They also have higher rates of high school graduation and employment.

Family and Friends

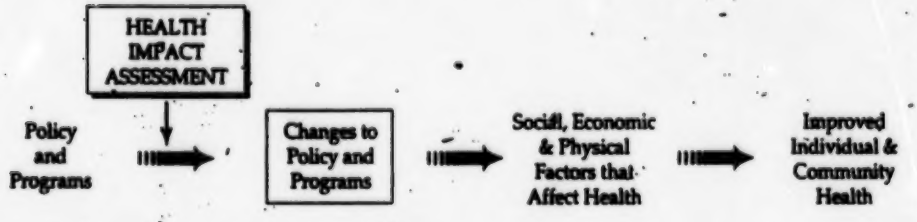
The support we get from our families, friends, and communities is an important determinant of a healthy, long life. Research shows that this support is as crucial to health as traditional factors such as diet and exercise.

Example: Action on Determinants of Health

The City of Parksville has established a participatory process to incorporate the health objectives of the community into the Official Community Plan. Through an intensive process of public input, such factors as economic diversity, conservation of ecosystems, and mixture of housing options have become the focus of the City's planning.

TAKING ACTION ON WHAT MAKES US HEALTHY

With the knowledge that health goes beyond lifestyle and medical care, we now need to take action to ensure that all policies and programs take health into account. The Health Impact Assessment Toolkit, published in 1994, is now being used by policy analysts as a standard step in the preparation of Cabinet Submissions in all B.C. government ministries. The new Health Impact Assessment Guidelines are now available as a resource for program planning and development.



What is Health Impact Assessment?

Health Impact Assessment (HIA) is a way to analyze your program's impact on the factors that affect human health and well-being. It is an adaptable process which can be applied to any program or service. It is a resource to guide thinking and discussion. It is not a measurement tool.

Where does HIA come from?

HIA reflects the knowledge that our health is closely linked with our economic, social, and environmental conditions. The provincial government's policy document New Directions for a Healthy British Columbia states that HIA should be incorporated into all policy and programs.

Why do HIA?

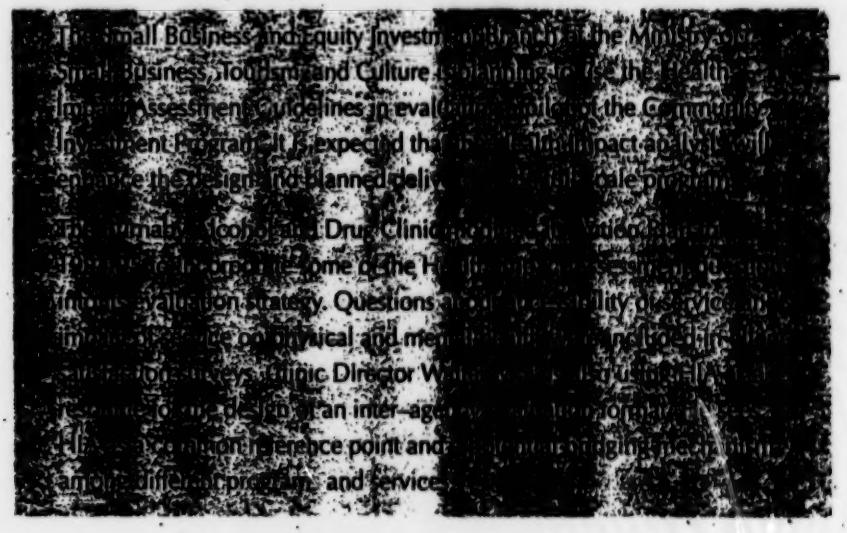
HIA is an effective way to focus on how our work affects health and well-being. It can be used to address impacts on the general public, clients, and staff. HIA can be applied at any stage of planning, evaluation, and resource allocation.

- In planning: to broaden the range of factors considered when creating and developing programs.
- In evaluation: to enhance effectiveness and build accountability when reviewing a current or completed program.
- In resource allocation: to guide decision making about what to fund.

Who should do HIA?

HIA should be done by anyone who is involved with programs. The process involves collaboration among managers, board and council members, frontline workers, and stakeholders.

HEALTH IMPACT ASSESSMENT IN ACTION



How do we do HIA?

1. ***Plan the process***
   - Jointly identify who should be involved in the process
   - Pick a time and place for doing it
   - Invite prospective participants
   - Distribute HIA Guidelines and any necessary documents to all participants

2. ***Facilitate the process (using a flip–chart or white board if possible)***
   - Ensure all participants understand the purpose of this process (ie., why we are planning or evaluating)
   - Define the scope of the process (ie., analyzing an entire program or a part of it)
   - Walk through the nine factors, jointly identifying which will be most fruitful to analyze in detail
   - Allow time for participants to use their HIA worksheets

- Lead a discussion on impacts, information needed, and action ideas
- Identify who will do what research and/or other action

3. ***Follow up on the process***
   - Document the HIA session(s) held and distribute copies to all participants
   - Check how people are doing with their research and/or action commitments
   - Plan additional sessions if necessary

4. ***Incorporate the results: into plans, evaluations, or resource allocations.***

USE THE HIA WORKSHEET TO ANSWER THESE THREE QUESTIONS:

A. **How will the program or service affect the following factors?**
The points listed under each factor are meant to stimulate your thinking. You are encouraged to identify additional types of impacts.

B. **What information do you need, if any?**
You may find it necessary to seek further information in order to examine some of your assumptions about expected impacts.

C. **What actions would increase positive impacts or reduce negative ones?**

FACTORS TO CONSIDER WHEN USING THE HIA WORKSHEET:

1. ***People's options and control over decisions that affect their lives:***
   - at home, at work, and at school
   - support systems
   - local governance
   - other:

2. ***Equity of access to services and programs, and opportunities to participate:***
   - First Nations people, cultural and linguistic groups
   - women, children, youth, seniors
   - gays and lesbians
   - people with disabilities, illiteracy, or mental health problems

- people who rely on public transit, cycling, and walking
- other:

3. ***The number and quality of healthy personal connections:***
   - family, friends, colleagues, neighbours
   - volunteer, neighbourhood, and community initiatives
   - physical fitness and activity
   - participation in cultural and spiritual activities
   - other:

4. ***The lives of our children and youth:***
   - meeting basic physical needs: food, clothing, shelter
   - play and learning that build self–esteem
   - strength of nurturing bonds
   - community participation, sense of connectedness with others
   - other:

5. ***The environment:***
   - reduction, re–use, and recycling
   - air quality, water quality, land quality
   - respect for and protection of biological diversity
   - function, safety, and aesthetics of buildings
   - ecology of land use and transportation
   - other:

6. ***Safety of individuals and communities:***
   - physical security, especially of women, children, seniors
   - respectful attitudes and behaviour
   - incidence of preventable injuries, diseases, deaths
   - access to safe food, water, shelter
   - other:

7. ***Lifelong learning:***
   - for people of all ages and income levels
   - learning how to learn
   - skill development to meet the requirements of existing and future jobs
   - mentor relationships
   - other:

8. ***Employment opportunities for individuals and communities:***
   - working conditions, participation in decision making
   - use of existing skills, development of transferable skills
   - stability of work
   - flexibility of hours, location of workplace(s)
   - access to childcare
   - jobs in communities facing high unemployment
   - other:

9. ***Economy and income distribution:***
   - economic growth
   - number of people in poverty
   - economic situation of women, children, and seniors
   - other:

	How will the program or service affect the following areas?
1. People's options and control over decisions that affect their lives	
2. Equity of access to services, programs, and resources	
3. The number and quality of healthy personal connections	
4. The lives of our children and youth	
5. The environment	
6. Safety of individuals and community	
7. Lifelong learning opportunities	
8. Employment opportunities for individuals and communities	
9. Economy and income distribution	

	What Information do you need?	Action Ideas?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

The following are some key resource and reference materials:

Determinants of Health (video; to borrow call 604–952–0876)
Victoria: Office of the Provincial Health Officer.

Our New Understanding of Health (booklet)
Victoria: Ministry of Health and Ministry Responsible for Seniors, 1993.

The Determinants of Health, CIAR Publication No. 5 (research paper)
Toronto: Canadian Institute for Advanced Research, 1991.

The Determinants of Population Health: A Critical Assessment (book)
Victoria: University of Victoria Department of Geography, 1994.

Why Are Some People Healthy and Others Not? (book)
New York: Aldine de Gruyter, 1994.

For more information about Health Impact Assessment or "Determinants of Health"

please contact:

Ministry of Health and Ministry Responsible for Seniors
POLICY DEVELOPMENT AND PROJECT MANAGEMENT
5-2, 1515 BLANSHARD STREET
VICTORIA, B.C. V8W 3C8

Telephone: (250) 952-1552
Facsimile: (250) 952-2247

Notes:

APPENDIX B

Health Goals for British Columbia

Health Goals for British Columbia

Goal 1:

Positive and supportive living and working conditions in all our communities.

The most important influences on our health are the conditions we experience in our day-to-day lives. Meaningful work, healthy and supportive workplaces, sufficient income, safe and well-designed communities, supportive families and participation in social networks significantly enhance our health.

Goal 2:

Opportunities for all individuals to develop and maintain the capacities and the skills needed to thrive and meet life's challenges and to make choices that enhance health.

Our personal coping skills, sense of identity and effectiveness, control over life circumstances, commitment to life-long learning and the lifestyle choices we make are key influences on our health. These personal capacities and skills are shaped during early childhood, further influenced by our day-to-day living and working conditions, and affect our resistance to disease at a biological level.

Goal 3:

A diverse and sustainable physical environment with clean, healthy and safe air, water and land.

Sustaining a healthy environment is essential to our long term physical survival and to our sustained social and economic wellbeing. As well, contamination of the physical environment can pose immediate threats to human health. Our challenge is to balance protection of the physical environment with the need for sustained economic activity while protecting human health and respecting the interests of individuals and communities.

Goal 4:

An effective and efficient health service system that provides equitable access to appropriate services.

Quality health services, when we need them, make an essential contribution to our health and well-being. At the same time unnecessary or ineffective health care can harm our health and use up public resources that could be better spent elsewhere to enhance health. Our challenge is to ensure that we have an effective system that balances public and health care provider expectations, available resources and evidence regarding outcomes of services provided.

Goal 5:

Improved health for Aboriginal peoples

Aboriginal peoples experience very significant health status inequalities that have occurred as part of the historical legacy of our province and country. This goal highlights the need for action to reduce these inequalities, including changes to ensure greater self-determination for Aboriginal communities.

Goal 6:

Reduction of preventable illness, injuries, disabilities and premature deaths.

A considerable number of our major health problems can be prevented through specific targeted interventions. This goal identifies achievable and measurable reductions in health problems that take a significant toll on the health of British Columbians, and for which effective prevention or early intervention strategies are available.

APPENDIX C

The Determinants of Health

The Determinants of Health

The factors that are generally referred to in health promotion/population health literature as the determinants of health can be divided up into categories a number of ways. Different organizations have chosen to divide similar sets of determinants up differently. Some organizations list certain factors such as gender among the determinants of health while others do not. The Health Canada Publication titled, *Towards a Common Understanding: Clarifying the Core Concepts of Population Health* (1996) for example includes genetic endowment and gender in its determinants of health typology while some other organizations have not. The following typology provides a succinct grouping of the determinants of health. It was this typology that was in use by the Federal, Provincial and Territorial Advisory Committee on Population Health when development of the Health Goals began (Federal, Provincial and Territorial Advisory Committee on Population Health, 1994).

Social and Economic Environment
Income, employment, social status, education and similar factors all contribute to health status.

Physical Environment
The natural and human built environment also contribute to health status.

Personal Health Practices
Individuals' lifestyles and choices contribute to health status.

Individual Capacity and Coping Skills
A person's competence, sense of control over their lives, and biological characteristics affect health status.

Health Services
Health services promote, maintain, and restore health.

APPENDIX D

Workshop Evaluation Report Survey Instruments

Workshop Participant Evaluation Form A (data included in analysis)

Workshop Participant Evaluation Form B (data excluded from analysis)

Follow-up Survey of Workshop Participants

Follow-up Survey of Action Workshop Participants

Follow-up Survey of Those Who Received the *Guidelines* Document by Mail

Workshop Participant Evaluation Form A (data included in analysis)

What did you think of the workshop?

Date_____

Your name (optional)_____Phone_____

1. What was your reason for attending the workshop?

_____

_____

2. What did you like about the workshop?

_____

_____

_____

3. What did you dislike?

_____

_____

_____

4. What do you feel was the most important outcome of the workshop?

_____

_____

_____

Workshop Participant Evaluation Form B (data excluded from analysis)

What did you think of the workshop?

Your name (optional) _____ Date _____

Town/City _____ Phone_____

Organization _____

_____

_____

Please help us to improve our work by taking the time to answer the following questions, and/or give your comments on the workshop:

1. What was your reason for attending the workshop?

_____

_____

_____

2. Did the workshop meet your expectation? Please explain.

_____

_____

_____

3. What was the most important thing you learned from the workshop?

_____

_____

_____

4. Do you intend to make changes as a result of this workshop? Yes No

If yes, what program do you plan to apply it to?

_____

_____

_____

5. How would you rate this workshop on a scale of 1 to 10?

1 2 3 4 5 6 7 8 9 10

Useless Very useful

6. Do you plan to use Health Impact Assessment in any planning, evaluation, resource allocation, or other activities? (Please describe)

_____

_____

_____

7. Are there any other comments you would like to make?

_____

_____

_____

Thanks for giving your feedback!

Please return this sheet to the workshop facilitator.

Health Impact Assessment (HIA) Project
Follow-Up Survey of Workshop Participants

The Population Health Resource Branch is following up with HIA workshop participants to get further feedback on the value of these workshops and some input on where the project should go from here. Please respond to the following questions.

1. How did the workshop affect your thinking about health and your awareness of the determinants of health?

2. Did the workshop adequately prepare you to use the HIA Guidelines booklet?

3. Have you shared the Guidelines booklet or any of the other information from the workshop with any colleagues or other associates?(How many, and who? Did they use it? If yes, how?)

4. Have you used the HIA Guidelines booklet? If yes, for what purpose?
   (or for what purpose do you plan to use it?)
   How useful has it been for this purpose, on a one to five scale (with one being low)?
   What actions, if any, have resulted from using the Guidelines?

5. Do you have any other feedback about the Health Impact Assessment workshops and resource materials?
   Would further support from the Population Health Resource Branch be helpful? If yes, what kind?

Thank you very much for responding. Please do not hesitate to contact Population Health Resource Branch (phone 604-952-1710 or fax 604-952-1713) for additional copies of the HIA Guidelines or further information on determinants of health.

Health Impact Assessment (HIA) Project
Follow-Up Survey of Action Workshop Participants

The Population Health Resource Branch is following up with HIA workshop participants to get further feedback on the value of these workshops and some input on where the project should go from here. Please respond to the following questions.

1. Did the workshop process identify any specific action ideas? (examples?)

2. What anticipated or unanticipated outcomes have resulted from the workshop?

3. Do you have any additional feedback about the Health Impact Assessment workshops or the Guidelines booklet?

4. Would further support from the Population Health Resource Branch be helpful in making use of Health Impact Assessment Guidelines?
   If yes, what kind of support?

Thank you very much for responding. Please do not hesitate to contact Population Health Resource Branch (phone 604-952-1710 or fax 604-952-1713) for additional copies of the HIA Guidelines or further information on determinants of health.

Follow-up Survey of Those Who Received the *Guidelines*

Document by Mail

Health Impact Assessment (HIA) Project
Follow-Up Survey

The Population Health Resource Branch is following up with people who have received copies of the HIA Guidelines booklet to get feedback on how it has been useful and what suggestions people have for future editions. Please respond to the following questions.

- For what purpose did you request the HIA Guidelines booklet?

- Was it useful for this purpose? (How has it been useful?)

- Do you have any suggestions for additions, deletions, or changes that should be considered for a future edition?

Thank you very much for responding. Please do not hesitate to contact Population Health Resource Branch (phone 604-952-1710 or fax 604-952-1713) for additional copies of the HIA Guidelines or further information on determinants of health.

APPENDIX E

Selected Tables From HIA Workshop Evaluation Report

Selected Tables From HIA Workshop Evaluation Report

The following tables indicate how the evaluators categorized responses to the questions discussed above.

"How did the workshop affect your understanding of health?" (From participant evaluation form)

Strengthened or reinforced my understanding of health	51%
Broadened my thinking about health	17%
Gave me a tool to use in applying my understanding of health	17%
Indicated a government shift in addressing health	3%
No change in my understanding	9%
Not sure or don't remember	4%

"Do you plan to use HIA for program planning, evaluation, resource allocation or any other purpose?"(From participant evaluation form)

Plan to use it	58%
Will try to use it	13%
Unsure	15%
Will not use it	13%
Will use parts of it	1%

"Have you used the *Health Impact Assessment Guidelines* booklet? If yes, for what purpose?" (From follow-up survey of workshop participants)

Yes, have used HIA for it's intended purposes	8%
Yes, have used HIA for other purposes	24%
Plan to or hope to use it	22%
No	46%

APPENDIX F

Health Impact Assessment Handbook and 1996 Draft *Guidelines* Document's HIA Instrument

Health Impact Assessment Handbook: Step by Step Guide

Plan the Impact Assessment
Host Action Workshops
Follow Up

Health Impact Assessment: *Step by Step Guide*

STEP 1: Plan the impact assessment

a. Jointly identify who should be involved in the assessment and whether to hold separate sessions for service providers and consumers. Schedule date(s), time(s), and location(s) which will be comfortable for the prospective participants. Identify who will facilitate, who will record, and who will arrange for refreshments.

b. Review the assessment framework, especially the five "types of impacts". and make any changes, additions, and deletions so that it better reflects the program mission or broad goals.

c. Distribute invitations to participate, along with the assessment framework (and a basic information sheet about the program for those who are less familiar with it). Invitations to consumers and other community members should clearly state why their input is being sought and that refreshments will be provided.

STEP 2: Host action workshop(s)

d. Through small group discussion, answer three questions for each of the five "areas of impact" (eg. What impact does this program have on social integration?...).

Q. 1: What impact does this program have?
Q. 2: What data or other information could be used as evidence of this impact?
Q. 3: What possible actions or changes would enhance this impact?

Alternatively, individuals may make notes in advance or during allotted time. Group discussion can then be used to combine these notes and identify next steps.

STEP 3: Follow up

e. Prepare workshop notes and distribute them to participants and other interested people, along with an explanation of how the information will be used..

f. Conduct a process which identifies information gathering or action ideas that can and should be implemented. Identify who will do what, and reporting time lines.

g. Follow up to ensure that implementation is proceeding. Document any changes to the program or other actions taken as a result of the assessment process.

Health Impact Assessment *Worksheets*

Cover page

Date: _____

Name of program, service, or category of programs/services to be assessed:

_____

_____

Names, roles, and phone numbers of people participating in the assessment:

NAME	ROLE IN RELATION TO THE PROGRAM	PHONE NUMBER

Other people we would like to include in the assessment process:

Worksheet 1

1. **Social integration**

- Relations with among family members, friends, and associates
- Informal support networks
- Participation in community and volunteer activities
- Participation in cultural and spiritual activities
- Other:

QUESTION 1 A: What impact does this program have on social integration?

QUESTION 1 B: What data or other information could be used as evidence of this impact?

QUESTION 1 C: What possible actions or changes would enhance this impact?

Worksheet 2

2. Education, skills and capacities

- Children and youth learning how to learn, building self-esteem
- Education/learning opportunities for all age groups
- Skill development to meet the requirements of existing and future roles
- Development of coping and problem solving skills
- Increased capacities to make healthy lifestyle choices
- Other:

QUESTION 2 A: What impact does this program have on education, skills, and capacities?

QUESTION 2 B: What data or other information could be used as evidence of this impact?

QUESTION 2 C: What possible actions or changes would enhance this impact?

Worksheet 3

3. Employment, economy and basic needs

- Working conditions, participation in decision making
- Family-friendly policies, access to child care
- Jobs for populations facing high unemployment
- Health of local and/or provincial economy
- Reduction of poverty
- Access to affordable, suitable housing
- Access to affordable, nutritious food
- Other:

QUESTION 3 A: What impact does this program have on employment, economy, and basic needs?

QUESTION 3 B: What data or other information could be used as evidence of this impact?

QUESTION 3 C: What possible actions or changes would enhance this impact?

Worksheet 4

4. Physical environment and safety

- Reduction, re-use and recycling
- Quality of air, water and land, and biological diversity
- Function, safety, and aesthetics of buildings
- Reduction of preventable injuries, disease and death
- Reduction of violent crime
- Respectful attitudes and behaviour
- Other:

QUESTION 4 A: What impact does this program have on physical environment and safety?

QUESTION 4 B: What data or other information could be used as evidence of this impact?

QUESTION 4 C: What possible actions or changes would enhance this impact?

Worksheet 5

5. Programs and services

- Equity of access for disadvantaged population groups
- Participation of program users in planning and evaluation
- Relevance to community needs and priorities
- Coordination with related programs and services
- Efficiency and cost-effectiveness of services
- Quality, efficiency and cost effectiveness
- Other:

QUESTION 5 A: What impact does this program have on programs and services?

QUESTION 5 B: What data or other information could be used as evidence of this impact?

QUESTION 5 C: What possible actions or changes would enhance this impact?

6. Other: _____

QUESTION 6 A: What impact does this program have on _____?

QUESTION 6 B: What data or other information could be used as evidence of this impact?

QUESTION 6 C: What possible actions or changes would enhance this impact?

Worksheet 7

Health Impact Assessment Summary

Check off which parts are completed. Also indicate which parts are partially completed. If some parts are deliberately left out, cross those out.

	Impact this program has on... (areas 1 - 6)	Information that could be used as evidence of this impact	Possible actions or changes would enhance this impact
1. Social integration			
2. Education, skills and capacities			
3. Employment, economy and basic needs			
4. Physical environment, safety			
5. Programs and services			
6. Other:			

Follow up plans

Record what person(s) will take what actions by what dates to ensure that the results of your health impact assessment session(s) get followed up on.

HEALTH IMPACT ASSESSMENT

FEBRUARY 29, 1996

DRAFT

FOR: THE POPULATION HEALTH RESOURCE BRANCH
BY: ANGELA LESKI

FACTOR	ELEMENTS WITHIN THIS FACTOR
Social support and integration *The quality of human relations and degree to which we feel comfortable in our own communities*	• Opportunities to develop positive and supportive interpersonal relationships and social networks • Participation in community based sports, recreation, social and cultural activities • Support for healthy family functioning, including childcare and education for effective parenting • Safety and security of communities • Other
Education *Life long learning opporutnities for children youth and adults*	• Opportunities for children and youth to learn how to learn • Opportunities and support for adult education • Skill development for current and future roles • Other
Income, employment and working conditions *Positive, supportive employment and working conditions and equitable income distribution*	• Diversity and sustainability of economic activities • Job creation, particularly for groups experiencing job status inequities • Quality of working conditions, including flexible environments that allow control over work activities, family freindly job policies (child care, job sharing, etc.) • Equitable income distribution • Other
Physical living conditions *The quality of life, safety and the accessibility of services to our communities*	• Accessibility of services and amenities to all residents • Mixed use community design, including pedestrian access, bicycle paths, public parks and green space, etc. • Availability of affordable, suitable housing • Other
Individual capacities and skills *Enhancement of coping skills, sense of identity, competence and personal effectiveness*	• Support for healthy early childhood development • Opportunities to develop and enhance individual coping skills and sense of control over life circumstances • Support for individual capacity to make healthy lifestyle choices • Opportunities for independence of persons who require assistance with daily living actitivities • Opportunities for authentic public involvement and participation • Other
The natural environment *An environment that is naturally diverse and has clean, health and safe ecosystems of air, water and land, for now and for future generations*	• Improvement of the quality of air and global atmosphere • Improvement and protection of water quality • Enhancement of the quality of land and soil • Access to safe, affordable and nutritious foods • Biological diversity • Green industries and products • Safe disposal of hazardous wastes • Other

IN WHAT WAY DOES THIS PROGRAM/ POLICY HAVE AN IMPACT ON THIS FACTOR?	WHAT POSSIBLE ACTIONS OR CHANGES WOULD ENHANCE THIS IMPACT?	WHAT INDICATORS COULD BE USED AS EVIDENCE OF IMPACT?

APPENDIX G

Other HIA Instruments and Processes

Other HIA Instruments and Processes

1. PATH Project Resources

The PATH (People Assessing Their Health) Project was a community-based health promotion initiative in Nova Scotia that was funded by Health Canada and implemented in 1996 and 1997 by the Antigonish Women's Association, the Extension Department of St. Francis Xavier University, and Public Health Nursing Services of the Eastern Health Region. The project involved communities identifying what determines health in their communities and developing tools to assess the impact of various initiatives on these determinants (PATH Project, 1997a). Groups in three communities (Guysborogh County Eastern Shore, St. Ann's, Whitney Pier) conducted exercises and meetings that culminated in publications that included HIA tools (PATH Project, 1997b, no date a, no date b). While there are differences between each of these tools, they are discussed below in combination.

Each of the tools consists of one or more checklists listing the factors that community members identified as the most important determinants of health for their communities. Beside each, users of the tools are asked to indicate how the initiative being assessed can be expected to impact upon each determinant. Various columns for comments are used between the three tools, including "Positive Impacts, Negative Impacts, Neutral Impact, Unknown Impact, Short Term Impacts, Long Term Impacts, and Action of Information Required." Essentially, other than making explicit within the worksheet itself that an initiative's impacts can be positive, negative, or neutral, the PATH Project HIA worksheets differ little from the existing *Guidelines* document's worksheet.

2. Policy Appraisal and Health

In 1995, England's Department of Health produced a document titled *Policy Appraisal and Health* (Department of Health, 1995). This document was designed to explain to public servants how the effects on health and health services

of policies, programs, and projects can be identified and how costs and benefits of alternative policies can be weighed during policy making. It is a companion document to HM Treasury's *Economic Appraisal in Central Government*. It is intended to assist in the appraisal not only of health policies but any policies that may have an effect on health.

While *Policy Appraisal and Health* is designed to facilitate consideration of the health implications of policies and programs just as the *Health Impact Assessment Guidelines* document is, the method chosen is very different. *Policy Appraisal and Health* is largely concerned with showing how anticipated health impacts can be quantified and valued to allow them to be integrated into more conventional cost-benefit and other analyses. *Policy Appraisal and Health* recognizes that such analyses must be done by experts, but that the document can help those who will commission and read such analyses to understand them.

As the *Guidelines* document must facilitate an HIA process that is easy enough for a decision-maker in a local health authority to use without expert assistance, *Policy Appraisal and Health* does not provide useful lessons for PDPM's revision of the *Guidelines* document.

3. **Guide to Assess the Health Implications of Public Policy**

In 1995, the Assistant Secretary to Cabinet (Social Policy) in Newfoundland wrote to Deputy Ministers "requesting that where applicable health implications be identified in Cabinet Submission" (Wayne Green, 1995). This memo was accompanied by a short document titled *Guide to Assess the Health Implications of Public Policy* that simply included a list and short explanation of the determinants of health as outlined by the Federal, Provincial and Territorial Advisory Committee on Population Health (Federal, Provincial and Territorial Advisory Committee on Population Health, 1994). There is no evidence that consideration of health implications in Newfoundland and Labrador Cabinet Submissions increased following this request.

4. **Making Public Policy Healthy**

In 1994, the Newfoundland and Labrador Heart Health Association produced a document titled *Making Public Policy Healthy*. *Making Public Policy Healthy* provides guidance for organizations who wish to improve health in their communities, businesses, etc. It includes information on how to liaise with outside organizations, develop a community profile, etc. This document was used as the basis for seminars delivered to provincial government departments and was distributed to various additional organizations in Newfoundland and Labrador including municipal governments and community groups. (Catherine Donovan, personal communication, June 30, 1998). While *Making Public Policy Healthy* does offer a wealth of information on how to effect change in a community, it does not provide any guidance on how to assess or predict the health impact of a policy or program. Therefore, its relevance to a revision of the *Guidelines* document is minimal.

5. **Creating Healthy Public Policy**

In 1998, the Open Learning Agency, in cooperation with Health Canada and the British Columbia Ministry of Health and Ministry Responsible for Seniors produced the *Creating Healthy Public Policy Worksnop Facilitator's Guide* (Open Learning Agency, 1998). The Healthy Public Policy workshops are being delivered on behalf of the Health Association of British Columbia to local health authorities.

The workshop includes a component that deals with choosing policy options and includes a simple HIA worksheet called a "Determinants of Health Scan". The workshop guide recommends that decision-makers consider the following questions regarding a given policy's expected impact on both health outcomes, and regional and provincial health goals and objectives:

- What is the positive/negative impact of this option on each outcome/goal and objective?

- What actions or changes would improve the positive impacts and minimize the negative impact of this option on each outcome/goal and objective? (Open Learning Agency, 1998).

The "Determinants of Health Scan" lists determinants of health and allows decision-makers to mark a (+) or a (-) beside each for each policy option under consideration based on whether the policy option is expected to have a positive or negative impact (Open Learning Agency, 1998). Users are asked to total positives minus negatives for each option. This approach is unworkable because no scale is attached to a given (+) or (-). A devastatingly negative impact could correspond to only one (-) while many very minor positive impacts may correspond to many (+)s. While relevant, the *Creating Healthy Public Policy* workshop guide does not provide any information that is useful in a revision of the *Guidelines* document.

6. European Commission HIA Activities

Article 129 of the Maastricht Treaty that established the European Community and the European Commission, its administrative body, states that "Health protection requirements shall form a constituent part of the Community's other policies" (European Commission, 1997). The 1997 Amsterdam Treaty's Article 152 strengthens the Community's involvement with health protection stating that "A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities" (Hubel, 1998). A variety of HIA related activities have already been implemented by the European Commission to meet its Article 129 obligations. These include the following:

- a mandatory internal consultation by the Directorate General in charge of public health on any proposal that could have health impacts; and,
- regular reporting on Community policies that incorporate health protection requirements (Hubel, 1998).

In a report on the integration of health protection requirements in Community policies, the Commission acknowledged the need for consistent methodologies to assess the health impacts of Community policies, and a committee on health established by the Commission has recommended the development of an easy-to-use checklist of steps in policy appraisal for health impact. These methodologies are as yet under development (Hubel, 1998). While the European Commission's HIA activities do not include a standard methodology or instrument that a revised *Guidelines* document could be based upon, the reports of the Commission do provide evidence that the European Commission is making a genuine attempt to consider health impacts in non-health policies (Commission of the European Communities, 1995, 1996, 1998).

APPENDIX H

Draft Health Impact Assessment Instrument

Health Impact Assessment Screening Tool (Draft)

Health Impact Asse ment Worksheet (Draft)

Health Impact Assessment Screening Tool (Draft)

This Health Impact Assessment Worksheet is intended to help decision-makers identify factors that contribute to health concerns and identify potential impacts of the policies and programs designed to address these health concerns. Ultimately, it is intended to help decision-makers create more effective policies and programs, and consider the broader impacts of these policies and programs on health.

While the Health Impact Assessment Worksheet may lead to valuable discussion and insight when applied to certain policies and programs, it will be less valuable when applied to others. Since it would be inefficient and time-consuming to apply the Worksheet to all existing and proposed policies and programs, decision-makers must select what policies and programs to examine using the Worksheet.

The screening criteria listed below outline factors you may choose to consider regarding where the Health Impact Assessment Worksheet should be applied. However, professional experience and judgement should ultimately determine what policies or programs are assessed using the Worksheet.

In circumstances where contributing factors, technologies, and outcomes are well understood, for example, immunization programs, a Health Impact Assessment may not be needed. Use the instrument where you feel it will be the most valuable. Factors to consider when deciding where to apply Health Impact Assessment are:

1. **The size and scope of the policy or program**
   While every policy and program is important, the time invested in completing a Health Impact Assessment will likely be most worthwhile when applied to policies and programs with far-reaching implications or a large client population. However, size and scope are only two factors to consider and in many circumstances you may wish to conduct a Health Impact Assessment of a policy

or program with a small scope and/or a small client population. The important thing is to conduct Health Impact Assessment where it will be the most valuable.

2. **Cost associated with the policy or program**

The cost associated with a policy or program is another consideration. Making the best use of available resources is important to any organization and is vital to improving health. You may choose to apply Health Impact Assessment to those policies or programs that account for large expenditures before those policies or programs that account for smaller expenditures. Spend time on Health Impact Assessment where you can have the greatest effect.

3. **Significance of impacts**

Policies and programs have significant impacts on people. Some policies and programs will have more significant impacts than others. You may choose to apply Health Impact Assessment first to those policies and programs that are believed to have or potentially have the most significant impacts.

4. **Number of potential or existing impacts**

Some policies and programs have relatively few impacts while others may have many. When the number of potential or existing impacts created by a policy or program increases, the value of carefully considering these impacts also increases. You may choose to apply Health Impact Assessment first to those policies or programs that have many impacts, since Health Impact Assessment can help you analyze these impacts and identify possible interactions among them.

5. **Probability of impacts**

Often, the exact impacts of a policy or program cannot be known. Typically, we are certain of some impacts and consider other impacts probable or possible. After a Health Impact Assessment, changes made to a policy or program will be

most likely in response to those identified impacts that are certain or probable. If a Health Impact Assessment identifies only impacts that are possible or improbable, changes to the policy or program assessed are unlikely. You may choose to focus your Health Impact Assessment efforts on policies that have more probable impacts.

6. **Opportunity to act upon assessment's findings**

Health Impact Assessment is most effective if there is opportunity to alter the policy or program that it is applied to based on the assessment. Normally, but not necessarily, this will require the use of Health Impact Assessment before a policy or program is implemented. There may be little value in conducting a Health Impact Assessment of a policy or program that is not likely to be modified as a result of the assessment.

Also consider what other organizations may be involved in the area of the policy or program being assessed. Are there elements other organizations will support or oppose? Will these organizations influence changes made to the policy or program in response to an HIA?

The above are several important considerations to take into account when deciding where to apply Health Impact Assessment. Different considerations will be more important in different circumstances. Because each situation is unique, the Screening Tool cannot determine for you where a Health Impact Assessment should be conducted. It can only assist you in making that decision.

Health Impact Assessment Worksheet (Draft)

The HIA Worksheet asks users to answer several questions in association with each of the Health Goals for British Columbia. Below is an explanation of the meaning and relevance of each question. For all answers, it may be useful to identify the degree of certainty associated with potential causal connections, and when discussing impacts, it may be useful to identify which impacts are expected to be long term and which are expected to be short term. Information does not need to be provided for every question under every Health Goal.

1. **In what ways do the determinants of health affect the health concern that this policy or program seeks to address?**

For each Health Goal, consider how the determinants listed may contribute to the health concern that the policy or program in question seeks to address. Often, you will not know if a causal connection exits between any single determinant or collection of determinants and a specific health concern. This uncertainty must be acknowledged but it is still valuable to identify what conditions exist which *likely* have an effect on the health concern that the policy or program seeks to address. In cases where a single factor's effect may be small but its effect in conjunction with another factor is great, this should also be noted.

2. **Considering those factors identified in answer to the question above, how should the policy or program be designed and implemented to be most effective?**

In answer to Question 1, factors were identified that contribute to the health concern the policy or program addresses. Question 2 asks you to consider these factors during policy or program development. Often, even if a policy or program cannot address determinants of health, such as income and environment, an awareness of the

importance of such factors in a specific context can influence how a policy or program is designed and implemented.

3. What positive or negative impacts will the policy or program have on the concerns highlighted by the Health Goals?

This question asks you to consider that the policy or program itself may contain elements that affect the determinants of health positively or negatively. While many determinants of health are difficult to change other than on a provincial or national level, others can be affected by local policies or programs. For each Health Goal you will be asked to consider how possible negative effects of the policy or program could be avoided or lessened, and how positive effects could be created or strengthened.

Goal 1: Positive and supportive living and working conditions in all our communities.

The most important influences on our health are the conditions we experience in our day-to-day lives. Meaningful work, healthy and supportive workplaces, sufficient income, safe and well-designed communities, supportive families and participation in social networks significantly enhance our health.

Question:

1. In what ways do the living and working conditions of the geographical target area, target population, or community at large contribute to the health concern that this policy or program seeks to address?

2. Considering the factors identified in answer to Question 1, is there any way that the policy or program could be made more effective?

3. Are there ways that the policy or program itself may *negatively* affect living and working conditions? How could these *negative* effects be avoided or lessened?

4. Are there ways that the policy or program itself may *positively* affect living and working conditions? How could these *positive* effects be achieved or strengthened?

Goal 2: Opportunities for all individuals to develop and maintain the capacities and the skills needed to thrive and meet life's challenges and to make choices that enhance health.

Our personal coping skills, sense of identity and effectiveness, control over life circumstances, commitment to life-long learning and the lifestyle choices we make are key influences on our health. These personal capacities and skills are shaped during early childhood, further influenced by our day-to-day living and working conditions, and affect our resistance to disease at a biological level.

Questions:

1. In what ways do a lack of such opportunities contribute to the health concern that the policy or program seeks to address?

2. Considering the factors identified in answer to Question 1, is there any way that the policy or program could be made more effective?

3. Are there ways that the policy or program itself may *negatively* affect individuals' opportunities as described in Goal 2? How could these *negative* effects be avoided or lessened?

4. Are there ways that the policy or program itself may *positively* affect individuals' opportunities? How could these *positive* effects be achieved or strengthened?

Goal 3: A diverse and sustainable physical environment with clean, healthy and safe air, water and land.

Sustaining a healthy environment is essential to our long term physical survival and to our sustained social and economic wellbeing. As well, contamination of the physical environment can pose immediate threats to human health. Our challenge is to balance protection of the physical environment with the need for sustained economic activity while protecting human health and respecting the interests of individuals and communities.

Questions:

1. In what ways does the physical environment affect the health concern this policy or program seeks to address?

2. Considering the factors identified in answer to Question 1, is there any way that the policy or program could be made more effective?

3. Are there ways that the policy or program itself may *negatively* affect the environment? How could these *negative* effects be avoided or lessened?

4. Are there ways that the policy or program itself may *positively* affect the environment? How could these *positive* effects be achieved or strengthened?

Goal 4: An effective and efficient health service system that provides equitable access to appropriate services.

Quality health services, when we need them, make an essential contribution to our health and well-being. At the same time unnecessary or ineffective health care can harm our health and use up public resources that could be better spent elsewhere to enhance health. Our challenge is to ensure that we have an effective system that balances public and health care provider expectations, available resources and evidence regarding outcomes of services provided.

Questions:

Are there factors related to effectiveness, efficiency and access to health services that may effect the health concern this policy or program seeks to address?

1. Considering the factors identified in answer to Question 1, is there any way that the policy or program could be made more effective?

2. Are there ways that the policy or program itself may *negatively* affect health services and/or access to them? How could these *negative* effects be avoided or lessened?

3. Are there ways that the policy or program itself may *positively* affect health services and/or access to them? How could these *positive* effects be achieved or strengthened?

Goal 5: Improved health for Aboriginal peoples

Aboriginal peoples experience very significant health status inequalities that have occurred as part of the historical legacy of our province and country. This goal highlights the need for action to reduce these inequalities, including changes to ensure greater self-determination for Aboriginal communities.

Questions:

1. Are the health status inequalities experienced by Aboriginal peoples relevant to this policy or program? If so, in what ways do these inequalities affect the health concern that the policy or program seeks to address?

2. Considering the factors identified in answer to Question 1, is there any way that the policy or program could be made more effective?

3. Are there ways that the policy or program itself may *negatively* affect aboriginal health? How could these *negative* effects be avoided or lessened?

4. Are there ways that the policy or program itself may *positively* affect aboriginal health? How could these *positive* effects be achieved or strengthened?

Goal 6: Reduction of preventable illness, injuries, disabilities and premature deaths.

A considerable number of our major health problems can be prevented through specific targeted interventions. This goal identifies achievable and measurable reductions in health problems that take a significant toll on the health of British Columbians, and for which effective prevention or early intervention strategies are available.

Note: If the policy or program being assessed does relate to preventable illness, injuries, disabilities or premature death, your answers to the questions under Goals 1-5 should already have adequately covered what factors contribute to the health concern the policy or program addresses. If the policy or program you are assessing does not relate to preventable illness, injuries, disabilities or premature death, please move on to the questions below.

Questions:

1. Are there ways that the policy or program itself may contribute to the above health problems? How could these *negative* effects be avoided or lessened?

2. Are there ways that the policy or program itself may lessen these health problems? How could these *positive* effects be achieved or strengthened?

Conclusion

The answers to the above questions should be drawn together and enhanced with information from other sources where necessary to form a broad picture of what determinants of health contribute to the health concern that the policy or program addresses, and what impact the policy or program itself may have on the determinants of health. An awareness of both these upstream and downstream influences can prove valuable in policy and program development.

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